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The effect of patient and therapist characteristics on premature dropout from the outpatient program of a crisis intervention unit

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INTRODUCTION

AIM

In assessing the effectiveness of psychiatric treatment facilities on patient improvement, investigators have examined the relevance of a wide range of factors. Traditionally, three factors, namely pre and post hospital symptomatology and performance, rehospitalization rates and premature dropout have enjoyed the greatest consideration. Of these, dropout has been the least difficult to assess but has been criticized for yielding the least information. There are some authors who regard dropout as an isolated phenomenon and not a measure of outcome at all, while others have associated the length of stay with the patient's success in treatment and improvement. In any respect, it is important to keep in mind that in most cases, premature dropout in and of itself precludes the assessment of other outcome criteria and on this basis alone would warrant further study.

It will be the major aim of this study to identify that information, if any, which would be useful in predicting which patients will drop out of therapy and which patient - therapist pairings will be most likely to reduce premature termination. We shall attempt this by collecting data on the demographic and personality characteristics of patients and therapists and on their expectations of therapy. These factors will then be examined as individual variables and as determinants of a given therapeutic interaction (i.e. an interaction seen as a differential pairing of given patient and therapist traits) affecting the incidence of dropout.

The present study is based on the assumption that dropping

out represents a negative phenomenon. Few convincing, systematic efforts have been made to put this hypothesis to the test of careful analysis, however, and it would not be unreasonable to raise the alternate possibility. That is to say, dropout may be an indication of strength or improvement for the patient and may minimize the amount of valuable time the therapist would have otherwise spent with an unresponsive patient. Nonetheless, consideration of the latter issue is felt to be beyond the scope of the present study, and the early identification and prevention of dropout shall remain as a focus for application of our findings.

JUSTIFICATION

The decision to explore the issue of dropout is felt to be warranted on the basis of two basic assumptions. The first as has been noted above, is that premature termination denotes a negative phenomenon, and, therefore, is inherently worth avoiding. The second is that the availability of information regarding the characteristics of dropouts and their therapists will enable psychiatric facilities to avoid or minimize premature termination by more specific patient-therapist matching and a modified approach toward the dropout prone individual.

In several investigations, authors found significant differences in degree of improvement between early terminators and those who remained in out-patient therapy, with the terminators scoring the least.[47, 4, 50, 51, 52, 58] Although there have been few other ventures into exploring this relationship, one can speculate, though guardedly, as to why dropout should be

viewed as a negative phonomenon. For the patient, dropping out may reflect a feeling of not have had his needs fulfilled or possibly of having had his needs fulfilled to the point of seeing further therapy as pointless or superfluous. Either of these may be secondary to an inadequate understanding by the therapist and patient of the critical issues and needs. On the other hand, they may be secondary to insufficient clarification of what therapy in general and the treatment facility in particular, have to offer.

Although no experimental evidence exists to support our claim, it would seem that in certain instances, premature termination is indicative of or feeds into and reiterates a feeling of hopelessness and isolation. This would be of special significance as a harbinger or sign of suicidal potential. To date, published data has been unavailable with regard to the relationship of dropout to suicidal behavior. However, preliminary analysis of the results of a study which was conducted in the same setting as that used for this study, did lend support to the "harbinger" speculation.[13] This study sought to compare on several outcome measures, patients admitted to the Emergency Treatment Unit of the Connecticut Mental Health Center with patients who, though appropriate for the E.T.U., were randomly redirected to other inpatient facilities. Tentative results reveal that dropouts from the E.T.U.'s thirty day routine outpatient follow-up program rated higher on a continuous four point scale denoting past suicidal thoughts, gestures and attempts, than did those patients who completed their outpatient phase and those patients who were referred from the outpatient program for rehospitalization. Although the criteria for rating suicide were not precise, it did seem striking that 25% of the dropouts in the study, compared to

0% of those completing follow-up and 8% of those rehospitalized, were noted to have made an actual suicidal attempt.

The latter results, however, were not upheld when, as a preliminary approach to the present research, a review was made of the data available for all those E.T.U. patients who went on to the E.T.U. out patient follow-up program during a twelve month period. As will be described more fully below, no significant differences were found between dropouts and remainers in the incidence of suicidal behavior. Thus, although we shall examine the population of the present study for a possible association between suicide and dropout, the issue of premature termination mirroring a feeling of hopelessness and isolation shall probably remain a speculation.

In further attempting to justify the claim that dropout is a negative phenomenon, one recognizes the importance of the fact that premature termination abbreviates the time available for providing the patient with adequate understanding and preparation for dealing with future problems. This temporal factor plays an especially significant role in the facility studied because of the nature of the limited inpatient time period inherent in a crisis intervention unit.

In addition, dropping out is usually indicative of termination on a negative note (i.e. without therapist consent), making the possibilities for future reliance on emotional assistance more difficult. Also it would seem to prevent, in many cases, an adequate resolution of problem areas which may have been uncovered. Once again this dilemma would be relevant specifically to a setting or facility such as the one being studied. That is to say, although deep seated long term

issues are usually temporarily left untouched during crisis intervention, the thirty-day outpatient follow-up phase is often the period during which such issues, which may inadvertently have been exposed, are either dealt with or covered over. Thus, any impingement of available time, which might result from a patient's dropping out, would make resolution of exposed issues an impossibility.

In surveying the negative implications of premature termination, one must take notice of how the therapist himself specifically suffers. The latter must deal with the frustrations and thoughts of not having provided adequate direction and assistance and of not having completed and carried through a challenge or task. Because of the shortened contact with the patient, there may be insufficient opportunity to obtain the feedback necessary to properly evaluate the effectiveness and success of one's techniques and therapeutic interventions. In addition, there is always the technical inconvenience and annoyance of time wasted because of unkept appointments.

Inside from burdening the psychiatric facility with some of the same problems it presents for therapists (i.e. the problem of unkept appointments and scheduling difficulties) premature dropout raises a key issue which must also be considered, namely that the facility is not providing enough or the most appropriate services for certain patients. Therefore, in institutions such as the Connecticut Mental Health Center, in which the facility is supposedly in part responsible to its constituent community, it may not be fulfilling its responsibility or else may not be adquately screening and redirecting persons who are deemed inappropraite candidates for its services.

Our second basic assumption, namely that once a potential dropout can be identified, steps can be taken to try to prevent the expected course of events, would follow from, but is not dependent on, the first assumption. Instead it would be dependent on the accuracy of the identifying criteria and the effectiveness of the modified approach. This study shall be directed toward delineating such criteria and testing several specific measurements which might be used in their assessment. With the accomplishment of these tasks, one could then provide suggestions for the modification of approaches and attempts at prophylaxis.

In presenting the justification for this dropout study, we must not avoid discussing, at this point, the essentially unique feature of our methodology. By this we are referring to our pursuit of identifying how differential matches of patients and therapists, aside from individual characteristics, affect dropout. The hypotheses regarding individual characteristics (both demographic and personality) and the findings noted in past research which served as a basis for their being proposed, shall be presented shortly. It will be clear from the literature review, however, that those hypotheses relating to patient therapist matching, have very little, if any, foundation in previous dropout studies. In recognition of this fact, Strupp and Bergin noted: "Patient personality characteristics.... demonstrably influence the therapists's effectiveness, which provides support for the conclusion that patients must be selected more carefully to match the therapists capabilities. Therapists have been differentially effective with particular patient groups; however, thus far it has not been possible to isolate salient dimensions." [57] These authors point out that

"while it may seem totally obvious that differential initial status should be paired with differential treatment, there is hardly a program of research which deals systematically with this problem." [57 p.46] Thus, although it would be inaccurate to rely on the paucity of available information as primary justification for this undertaking, one cannot ignore the impetus it provides to our efforts.

SETTING

FACILITY

The Emergency Treatment Unit (E.T.U.) of the Connecticut Mental Health Center (C.M.H.C.) was chosen as the site for carrying out this study of dropout. Its selection was based in part on the author's familiarity with and commitment to this unit, which followed his having spent six weeks there as part of a medical student clinical clerkship. Interest and enthusiasm in exploring the nature of premature termination arose from both having observed and experienced this phenomenon and from discussion with other members of the E.T.U. staff.*

Of the outpatient programs functioning within and about Yale-New Haven Medical Center, that of the Emergency Treatment Unit presents itself as one which, for reasons alluded to earlier, would be an especially important and interestig one in which to study the issue of dropout. Other factors which make it a desirable setting, include the large number of patients which go through the program each year. For example, during a twelve month period in 1969-1970, 435 patients were admitted to E.T.U.'s inpatient service. Of these, 68% or 295 went on to be followed in E.T.U.'s outpatient program. In addition, E.T.U. is unique in that essentially everyone

* Unless one were to expand the implication of "dropout" to include those patients who leave psychiatric inpatient services without the advice and consent of those individuals responsible for them, one is obligated to study an outpatient population.

involved in its outpatient phase has undergone some acute emotional crisis or exacerbation of a chronic illness almost immediately prior to their entering this phase. Since the outpatient segment of treatment was initially devised to allow adequate time for working out the crisis while limiting the number of days of hospitalization and complete dependence on the unit, to as minimal a level possible, dropout would grossly impede the operation of such a facility.

As a final justification for the selection of E.T.U. as our setting, one would offer the fact that because of the relative paucity of crisis intervention facilities, very little is known about them. This unfortunately also has the disadvantage of providing an inadequate fund of knowledge and findings on which to base our own and future studies. It is, in part, for this reason that the present venture can realistically be no more than a pilot study. The other major limiting factor is the lack of sufficient time to run a pre-test of our methods and design. Therefore in a sense this study shall be the pilot study, from which further research in the area may gather direction and foundation.

The history of the Emergency Treatment Unit dates back to January 1, 1967 when it was established as a unique but integral element of the therapeutic services offered by the Connecticut Mental Health Center. The latter is a joint, federal and state funded institution offering psychiatric inpatient and ambulatory services to persons residing in a geographically circumscribed portion of the state. It hires and supports its own para- and non-medical personnel as well as a small portion

of the medical personnel. The Center is in close proximity to and operated in conjunction with the Yale-New Haven Medical Center, which serves as one of the major sources of referrals to the center. Full-time and resident medical (psychiatric) personnel are provided by the Department of Psychiatry of Yale University.

The aim in creating E.T.U. centered about a desire to provide a more appropriate approach toward fulfilling the needs of lower socioeconomic class patients with emotional problems. The goal the setting aimed towards was "helping the person focus on current life struggles in order to facilitate the individual's return to the level of functioning that preceded the disruption and crisis that led to his seeking hospitalization." 62 p.620 The two key features which were developed with this goal specifically in mind were the relative brevity of the intervention and the anti-nurturant, responsibility-inducing nature of the services. Both of these shall be described more fully following a brief account of the manner in which patients are admitted.

The two prerequisites for admission to the inpatient service of E.T.U. are: 1) the person's having undergone a recent emotional crisis or acute exaccerbation of a chronic psychiatric problem; and 2) the person's residing within the predefined "catchment area." At least two thirds of the admissions originate from the emergency room of Yale-New Haven Hospital. A small proportion come directly from the Evaluation and Brief Treatment Unit (EBT). The latter is an outpatient service operated within C.M.H.C., which sees patients with psychiatric complaints for a limited number of sessions. If

the emotional upset is deemed too intense to be handled in an ambulatory clinic, E.B.T. will transfer patients to a hospital. Having seen the patient the psychiatric resident from the emergency room or therapist from E.B.T. consult with the E.T.U. nursing staff member in charge of admissions for that day. The latter confirms whether or not the candidate is appropriate and taking into account the management problems currently hospitalized, makes the final decision about admission.

The first of the two key features of the psychiatric intervention as it exists at E.T.U., namely brevity, is accomplished by clarifying certain points with the patient prior to his being admitted. The first point is that E.T.U. will provide no more than five days of inpatient service. Secondly, all E.T.U. patients except those who are referred directly to other outpatient modalities or to long-term hospitalization, will be able to participate in the E.T.U. thirty day outpatient follow-up program immediately following their discharge from the inpatient period. During the thirty day period a patient may be seen as often as needed, but once per week for about a month is the usual case.

Although brief, the hospitalization at E.T.U. is a relatively intensive and active one. Each patient is assigned a team leader or primary therapist, but also is seen by a number of additional members of the staff each day. In this way, the possibility of discovering at least one therapist whose approach is effective, is more likely. A typical day would consist of breakfast, followed by the morning patient staff meeting. Patients and staff, sitting together in an open circle, listen to new patients introduce themselves and their

crisis precipitating events. Team leaders are selected for the new patients and an initial work plan is mapped out.* "Old" patients are asked to bring everyone up to date on the course of their situation and their further plans. This meeting is followed by each patient's undergoing two or three half-hour individual interviews with different staff members for the remainder of the morning. Progress.notes are recorded in the patient's chart by therapists, following each interview. Then after lunch the staff meets alone to discuss how each patient has been progressing and to make suggestions to the team leader and others responsible for a given patient. The remainder of the afternoon and early evening is spent interviewing either patients or their family members and other significant individuals responsible for or affected by the crisis situation. In some instances these individuals are seen together with the patient as a family or couple. The final event of the day is a second patient-staff meeting late in the evening. Only a few staff are present and it is usually much more informal than its morning counterpart, resulting in a greater degree of inter-patient involvement.

* The selection of team leaders, though not random, is based on certain uniform factors. The latter are: a) therapist's interest in a given patient; b) the "availability" of a given therapist as determined by his current caseload and whether or not he is working the evening or night shifts; c) the supervisor's feeling as to whether a certain patient would provide a good learning experience for a given therapist.

The success of the brevity of contact relys heavily upon the effectiveness in achieving the second key feature, namely, the encouragement of patient self direction and responsibility. The importance of the patient's presenting his crisis and backround information as completely and as rapidly as possible is stressed along with the necessity of his taking as active a role in planning his hospital and post discharge course as is feasible. Thus every effort is made by both parties to minimize the dependency on the hospital which often occurs following an overwhelming emotional crisis. Although intra-psychic and interpersonal issues are a primary focus of therapy, equal and often greater emphasis is placed on working out problems and conflicts concerning "reality issues." For example a team leader may assist the patient in locating a living arrangement away from parents, or in getting a less demanding position at work. In this way, some of the anxiety provoking obstacles in the way of confrontation with deeper, primary issues, are overcome.

As a part of the attempt to allow the patient to direct his course and recovery as much as possible, he is usually given the initial responsibility of arranging for family and significant others to meet with members of the staff. In keeping with the temporal restrictions, the aim is to achieve this within twenty-four hours of a patient's being admitted. When he deems it useful, a patient may ask to be seen as a couple with his spouse, or as a family. Besides interviews, other therapy modalities such as psychodrama may be utilized. Medications, the phenothiazines primarily, are employed in about two thirds of all admissions. Frequently, the patient himself is encouraged to decide the dosage necessary. Finally

the task of deciding when to be discharged to the outpatient phase or whether further, long term, hospitalization is necessary, is a decision which actively involves the patient.

The physical setting in which E.T.U. operates is notable in two major respects. First are the relatively compact quarters. There are four bedrooms with accomodations for seven, bathroom facilities and a fifth room used as a nursing station. All of these open onto a small lounge with a couch, television and phonograph. Several offices and a large "day room," which is used for both patient-staff meetings and as a dining room, complete the facilities. The second unique feature is that E.T.U. avoids the isolated "locked" nature of most psychiatric wards in that it occupies a portion of the main floor of the Connecticut Mental Health Center. The doors of the unit open directly onto the main waiting room of the Center and patients are free to use the latter as well as the grounds just outside the center, for lounging purposes. In this manner, the facilities are arranged to reinforce the attempt at keeping patients from becoming secure and overly dependent on the institution which would make a return to pre-crisis functioning a further step away.

In order to provide the intensive treatment necessary on a brief-stay ward, the staff to patient ratio is kept high, especially during the day shift. The staff is made up of a full-time psychiatrist-director, 7 nurses, 8 psych. aides, a social worker and usually a chaplin who works part-time on E.T.U.. Two full-time secretaries handle clerical tasks. In addition there have been from 3-5 psychiatric residents who rotate through E.T.U. every 2-6 month period and a variety of other trainees. The permanent staff range in age from 23 to 62, are one third male and one third black and are varied

social and educational backrounds. About one third of the full-time non-medical personnel have worked on the unit for more than half its life span, whereas the psychiatric residents rarely spend more than six months there. Except for the handling of medications most of the non-administrative patient-oriented responsibilities are assumed on a relatively equal basis by all members of the staff. Nurses and psych aides transcend their traditional roles to become team leaders and thus the primary therapist responsible for a given patient. In so doing, they handle tasks typically thought of as being in the physician's, and social worker's, domain, such as psychotherapy, couples and family work and making decisions about the need for psychoactive drugs in a given case. Aside from directing the patients' inpatient course, the team leader assumes the job of contacting individuals and social agencies who might be involved in an individuals' disposition, as well as either functioning as their outpatient team leader or arranging for another member of the staff or other outpatient facility to be responsible for their post-hospital therapy.

The non-permanent E.T.U. staff, namely second and third year psychiatric residents who rotate through E.T.U., act as team leaders and perform many of the same functions as the full-time personnel. Together with the director, they provide the necessary, medical back-up and exchange their theoretical expertise for skills and knowledge the permanent staff has acquired from first-hand experience. In this way the unit constantly strives to fullfill an educational as well as service oriented role. In this same vein, it accepts for training, individuals who have been hired to work in community based psychiatric"field stations" as well as students from the divinity and medical schools of Yale University. Although, additional commitments have occasionally limited the amount of time the temporary staff can devote to E.T.U., their presence,

nonetheless, adds another dimension to patient care.

TIME PERIOD

The time span selected for the present study was four calendar months. All patients admitted to E.T.U. between September 20, 1970 and January 20, 1971 were administered our questionnaries. All of those in this group who went on to the E.T.U. 30 day out-patient follow-up program, were selected for our research population. Four months was selected as practical period, on the basis of the average admissions and dropout rates of previous years. It was hoped that these four months would provide us with a population of about 100. That is to say, since the most recent E.T.U. tally had shown on average monthly admission rate of 36, with about 25 new E.T.U. 30 day-outpatients per month, four months would give us the number we desired. If the dropout rate remained the same as in the past (i.e. 17.3% of all new ETU outpatients) we would expect about 17 new dropouts during the four months.

It was felt that such a population, namely 100 subjects and 17 dropouts, although not ideal, would suffice in a pilot study such as this one. It had to be borne in mind that even though the collection of patients would end on January 20th 1971, the actual collection of data would go for about one to one and half months beyond that date, when the last subject would complete his "30-day outpatient phase."

POPULATION

REFERRING AGENT:

During the four month period a total of 144 patients were admitted to E.T.U. Of this group, 88 (61%) were discharged to the E.T.U. 30-day outpatient program and, therefore, made up our population. This compares well with statistics for a previous 12-month period, July 1969 - June 1970 (see table 1), during which 59% of all E.T.U. admissions went on to the E.T.U. outpatient phase. Of our 88 subjects, 65% were referred from the emergency room of Yale-New Haven Hospital. This varies little from the 70% rate reported for all admissions during the first two years of operation ofthe unit. (see #121) Thirty-two percent of our subjects came from the Evaluation and Brief Treatment Unit (E.B.T.), operating adjacent to E.T.U. and described previously. The remaining 3% were referrals from various non-E.T.U. outpatient programs.

DEMOGRAPHY:

As in the past, about 85% of our population ranged in age from 14 to 40 years. Thirty-four percent were between 14 and 20, 27.3% between 21 and 30, 23.8% between 31 and 40, 9.1% between 41 and 55 and only 5.7% greater than 55 years. In general, these percentages are similar to what has been seen in the past (see table 1) except for one major exception. The latter arises from the fact that patients between the ages of 14 and 20 made up only 19% of all E.T.U. admissions during the units' first two years of operation. Although the 27.2% and 34% found in the 1969-1970 review and in this study respectively, were for only E.T.U. admissions going on to E.T.U. outpatient

TABLE 1

STUDY PATIENTS		Weisman all adm.	12mo.rev only adm.who go on to ETU	Our Study 30day OP Prog	12mo.rev	Our Study	
			DO+Rem	DO+Rem	Dropouts	Dropouts	Remainrs
#months		24	12	4	12	4	4
TOTAL ADMISSIONS		900	435	144	-	-	-
ETU OUTPATIENTS		-	296 (68%)	88 (61%)			
DROPOUTS			51 (17%)	22 (25%)			
AGE (%)	14-20	19	27	34	27	36	33
	21-30	41	38	27	51	36	24
	31-40	20	19	24	10	23	24
	41-55	13	15	9	10	5	18
	>55	7	1	6	2		
SEX (%)	male	37	31	33	31	36	32
	female	63	69	67	69	64	68
RACE (%)	white	80	76	83	69	64	89
	black	17	24	17	31	36**	11
	p.r.	3					
MARITAL STATUS (%)	sing.	40	41	43	48	36	46
	mar.	34	40	36	36	27	39
	sep.	13	12	15	6	36	15
	div.						
	wid.						
EDUCA.	12		38	35	50	46	38
	HSG		28	34	27	36	53
	pt.col		12	15	8		
	col.gd		4	4	2	9	6
	gd.sch		1	3	0		
	unknown		17	9	13	0	0
	vocat.					9	3
SOCIAL CLASS (%)	I	4		5		0	6
	II	6		8		9	8
	III	15		23		9	27
	IV	39		37		50	33
	V	37		27		32	26
DIAGNOSIS (%)	Adj.Rxn	5	12	12	8	14	12
	Ch.Dis.	5	14	14	10	18	12
	Neur.	28	35	39	53	50	35
	Lat.Sch	10	5	7	2	0	9
	Psycho.	38	27	25	12*	9	30*
	OBS	6	1	1	0	0	2
	Addict'n	7	6	2	14	9	0
SUICIDE (%)	attempt	7	5	6		9	5
	gesture	13	23	36		41	35
	thoughts	29	24	16		18	15
	none	51	50	42		32	46
REFER. (%) SOURCE	YNHH-ER	66		65		68	64
	EBT	19		32		32	36
	Other	11		3			
PREV. HOSP.(%)	yes	39		18		5	23
	no	61		82		95	77

*-p<0.01
**p<0.025

therapy and not for all admissions, these values are, nonetheless, analagous to the 19% value. This is by virtue of the fact that patients who get E.T.U. outpatient therapy as their post-hospitalization disposition, have never differed significantly in age from those who get other outpatient therapy or hospitalization as their disposition. The reason for this obvious trend toward admitting more teenage patients than in the past is not yet clear. As will be demonstrated below there has been little change in the E.T.U. patient diagnoses and their frequencies over the years; therefore, one cannot implicate an increase in drug related admissions as the causal factor. Elucidation of the latter shall await further investigation.

Both sex and race ratios have remained remarkably constant throughout E.T.U.'s history. Sixty-seven percent of our subjects were female and 83% were white. These values are within five percentage points of what we might have expected judging from statistics of previous years. The 17% of non-white subjects in this study were black. Although Spanish speaking citizens make up a considerable proportion of E.T.U.'s catchment area population, they have never accounted for more than 1 or 2% of the admissions. This tendancy prevails throughout C.M.H.C., and would not appear to be specific to E.T.U. The religious affiliation of our population was largely Roman Catholic and Protestant with 47% and 45% of our subjects falling into the two respective categories. Only 6% of the 88 were Jewish, while the remaining 1% were Greek Orthodox. Because of insufficient data, it was not possible to compare our subjects, religious breakdown with that of past years.

Forty-three percent of the patients involved in this study

were single while 36% were married. In addition 15% were separated, 4.5% divorced and 1% widowed. There are essentially no differences between these and past findings concerning patient marital status. Similarly, our population distributed in a fashion almost identical with previous patients, when compared on the variable of education. That is 35% of our subjects had less than a high school diploma at time of admission, while about an equal percentage did achieve this level. About 15% had some college training, 3.4% had completed college and another 3.4% had done some graduate work. Of the remaining 9%, half had completed vocational school training and for half this information was unobtainable.

One of the few demographic variables on which our group of patients varied from the E.T.U. admissions of the unit's early days, was that of social class. Our breakdown was 4.5%, 8%, 22,8%, 37.5% and 27.2% of all E.T.U. outpatient program-bound admissions from class I to class V respectively.* These findings indicate that slightly, but not significantly, fewer class V patients are being admitted this year than in the past, when the value was noted at 37%. Unfortunately, the 37% figure referred to the percentage of all E.T.U. admissions and was not accompanied by a breakdown according to post-inpatient disposition. As a result, we cannot speak too assertively about the changing trend, which, although not a significant observation statistically, is certainly an interesting one.

* Socioclass was computed according to Hollingshead and Redlick's two-factor index.[33]

PATIENT SPECIFIC CHARACTERISTICS

Of the 88 patients in our population, 72 or 82% had never been hospitalized prior to their coming to E.T.U. In addition to the 18% who had been inpatients at some other institution, there were 6, or about 7%, who had been hospitalized on E.T.U. previously. The only reliable data from prior years indicated that only 61% had no prior history of psychiatric hospitalization at the time of their admission to E.T.U. However, it must be noted again that this 61% referred to a segment of all admissions and not, as our data refers, to only E.T.U. outpatient program-bound admissions. And, in fact, assuming that patients who get long term hospitalization as their post-E.T.U. disposition are more likely to have a history of having been hospitalized in the past, one is not surprised by , and would even expect, a higher rate of previous espisodes in the Weisman review than we note in our own analysis.

The Majority, or almost 39%, of our population carried the diagnoses of either neurotic depression, reactive depression or depressive reaction. Twenty-five percent were classified under schizophrenia (acute, chronic, paranoid or reactive) while about 7% were categorized as latent, incipient or "borderline", schizophrenics. The remaining four categories of adjustment and situational reactions, character disorder, organic brain syndrome and addiction (drug and alcohol) accounted for 12.5% 14% 1% and 1%, respectively, of our subjects. As is evident in Table #1 , this distribution is in close accord with that of previous years.

Upon examining the suicidal potential of our patients, we noted

that only 42% exhibited no history of suicidal tendancies. Of the 58% who did, however, about two thirds (i.e. 36.4% of all our subjects) exhibited behavior classified as "gestures". More than a quarter (i.e. 16% of all our subjects) had suicidal thoughts and about a tenth (i.e. 5.6% of all our subjects had made an actual suicide attempt. These observations were noted to be quite different from those noted for earlier years. (see Table #1) The 1966-1967 review of all admissions, for example, indicated that only half of the patients had demonstrated some suicidal potential. And only a quarter of this half (compared to our own finding of two thirds) were gestures. Instead, suicidal ideation seemed to predominate and was almost twice as common as it was in our group. When the twelve-month (1969-1970) retrospective review of all E.T.U. outpatients was performed, data concerning suicide could be gleaned for all but 25% of the patients. Of the three quarters for whom there was data, half had no suicidal behavior, 24% had only thoughts, 23% had made gestures and 4.5% had made actual attempts. Therefore, it would be reasonably safe to suggest a trend within patients coming to E.T.U. toward a greater number of suicidal gestures without a concommitant increase in the number of earnest attempts. Whether such behavior has become a more successful or acceptable mode of seeking emotional assistance cannot be adequately answered at the present time. Let it suffice to say, our subjects were unique, or else harbingers of a trend from the standpoint of suicidal behavior, in that, when they manifested this behavior it was more commonly in the form of gestures than we had expected. (It should be noted that the 25% of patients from the 1969-1970 year, for whom suicidal potential could not be ascertained, was a random sample as far as the author could

determine.)

Thus, from a demographic standpoint our subjects comprise a group relatively comparable to previous E.T.U. outpatient groups and previous nonoutpatient-bound E.T.U. inpatient. Although it was not possible to examine nonoutpatient-bound E.T.U. inpatients who were admitted during the time period of this study, there was no indication that this group differed from that discussed by Weisman et.al.[62] It will, however, be important to bear in mind the fact that we have not yet ruled out the possibility that our subjects vary demographically from the other E.T.U. patients admitted during the four month time period.

THERAPEUTIC MODALITIES

Every subject in our group received individual interviews as the major therapeutic intervention during both the inpatient and the outpatient phase. In addition, however, four patients had family meetings as a major adjunct to their outpatient therapy. Thirteen patients, about 15% of our population, were seen with their spouse as a couple during the outpatient period, and nine individuals had sessions with their therapist in their own home.

THERAPIST CHARACTERISTICS

Demographic data was collected from, and our questionnaires were administered to every permanent and part-time therapist who spent at least one day seeing patients on E.T.U. during the time period of our study. This amounted to 33 individuals,

14 of whom were psychiatric residents who spent part of each day on E.T.U. (The one exception to the latter was the chief resident whose major and almost total responsibility was on E.T.U.) Of the 33 therapists, only 22 served as primary outpatient therapists for at least one of our 88 subjects. From this point on, we shall refer to this group of 22 when we refer to our "therapist sample." (It should be kept in mind that sample here does not imply a randomly selected group.)

Sixty-eight percent of the sample were between the ages of 23 and 30, while almost 14% fell into the fourth decade and 18% were noted as older than forty years of age. Over a third were noted as older than forty years of age. Over a third were female and 18% were black (the rest being white). The distribution according to marital status was 27%, 41% and 32% for the single, married and separated-divorced categories respectively.

Eighteen percent of the therapists had graduated from a four year college program while 41% had done graduate work as well (medical school in most of the cases). The other 41% had attained either a high school diploma or had completed some college but less than a bachelors degree (three year nursing programs in most cases.). The titles of therapists, although less of a distinguishing characteristic on E.T.U. than in the typical psychiatric facility, varied from psych aide, to psychiatrist to nurse to social worker. Twenty-seven percent of the group were psych aides, 36% were nurses and the remaining 36% was made up of physicians and social workers. As to the extent of experience each of the therapists had working on E.T.U., it was noted that 41% of the 22 had six months or less, while 32%

had between 8 and 16 months and the remaining 27% had from 24 to 48 months on E.T.U.

SUMMARY

In summary, our population, with the exception of exhibiting slightly more teenage patients, somewhat more class V individuals and a higher incidence of "gestures" as a demonstration of suicidal potential, is quite representative demographically of patients of past years who have been discharged to the E.T.U. outpatient program, as well as of all E.T.U. admissions in general. Because of the short, four year, history of the unit, and the relatively slow turnover of permanent staff a retrospective comparison of therapist characteristics was not performed.

FOUNDATION FOR HYPOTHESES - A review of past literature and an analysis of a highly similar population.

To aid in developing our plan of approach, an exploration of relevant past research in the area of premature termination was carried out. These studies utilized a number of similar and dissimilar variables related to dropout. None of the previous projects, however, were done with a population and setting such as our own. Therefore, the 12-month retrospective review of E.T.U. statistics for the 1969-1970 year, was used, when possible, to supplement and provide a more specific basis for our design. The manner in which this review was made, and its own limitations shall be described with the methodology of this study. Owing to the extent and variability of the factors studied, we shall present the findings by variable rather than by author. Whenever appropriate, a comparison with the results of our retrospective review shall be included in the discussion of a given variable.

QUALIFICATIONS TO THE INTERPRETATION OF PAST RESEARCH

Since our discussion of the literature shall proceed by variable, an account of the basic differences between past ventures and our own, shall be more easily made at the outset. Of those differences limiting the comparison, the most significant and, unfortunately, unavoidable one concerns the definition of "dropout" itself. In no previous study nor in our own twelve-month review are the criteria for dropout equal to our own. A review of past research revealed that most of

the criteria for defining "dropout" from the outpatient psychiatric and school counseling programs under scrutiny, have been similar to a degree. Most studies seemed to have used the median number of sessions for the entire population, as the factor to discriminate a dropout from a remainer. In most instances the number of visits before which a patient's leaving therapy without the advice and consent of the therapist would classify him as a dropout, had been six [28, 7, 42, 48, 34, 30, 23, 25, 26, 27]. McNair et.al.[44] had used sixteen sessions as the cut-off point, Winder et.al.[66] used eleven and Frank et. al[14] used four. On the other hand, most of the studies, in comparing dropouts with "remainers" or "stayers", have disagreed as to the duration of therapy necessary for a subject to be classified as being in one of these "anti-dropout", categories. These "remainer" criteria have varied from six [5] to thirteen [34] to twenty [30, 66] to twenty-six weeks. [48, 42]

Aside from the important difference in dropout criteria, most premature termination studies manifest variation in the basic nature of the setting or population. In most instances, psychiatric outpatient clinics were involved, in which an individual is expected to remain in therapy a considerably longer period of time than the thirty day course typical of the E.T.U. outpatient program. In addition, many of the more informative and significant experiments and results came from the outpatient services of Veteran's Administration hospitals. [42, 48, 58] As a result, these studies automatically controlled their populations for several variables including sex and income. Although, as shall be pointed out below, neither of these

variables appears to bear a significant relationship to drop-out, the situation or environment created by patients' being predominantly of one gender or income group may play a significant role.

In the studies of several authors, the subjects were college students who had come to the school psychologist for personal counseling.[34, 23, 24, 25, 26] It becomes apparent, that one cannot easily extrapolate from the dropout-related findings of such research; however, in one case the authors had gone on to re-test their hypotheses using a patient rather than student population.[27]

Another manifestation of the dissimilar nature of the premature termination issue, rests in the wide disparity in actual incidence of the problem. Although the variation in dropout criteria obviously plays a major role, the degree of disparity makes other, yet unrecognized, factors very likely. Of the total 435 patients admitted to the Emergency Treatment Unit during the twelve months encompassed by our retrospective review, 295 were assigned to the 30-day outpatient, follow-up program. The other 139 received as their discharge disposition, either long-term hospitalization, referral to a private therapist, or referral to another outpatient program. In addition, there were two or three patients each month who "left town" or signed themselves out of the inpatient service against medical advice. Of the 295 patients, 51 or 17.3% were noted as "not having kept appointments and having received termination without the advice and consent of their team leader. (The differences between the dropout parameters of this retrospective review and the present study are discussed as part of our methodology.) Accounting

for a small number of false negatives which probably went undetected in our review, one might estimate the true rate of dropout during the twelve months to be between 18% and 20%.

Upon reviewing the dropout studies which have been carried out in the past, one readily observes that the E.T.U. attrition rate is fairly low by comparison. Rosenthal and Frank[47] reported that 50% of the V.A. psychiatric outpatients in their study failed to attend at least six sessions (i.e. the cut-off point for dropout and remainer) and terminated without the therapist's approval. They also noted that 10% of the patients terminated after 6 to 10 sessions, 25% after 11 sessions and only 16% went for more than 20 sessions. In 1957 Frank et. al.[14] reported a 31% dropout rate (i.e. terminated without approval prior to the fourth session) and indicated that in their review of the literature they found that most programs reported a rate between 30% and 65%. In a study done with patients from the same geographic location as that which served as our own source, it was reported that 25% of patients who visited their outpatient clinic, failed to return for at least three more visits scheduled within two months.[63]

The statistics regarding dropout from college counseling services turn out to be quite similar to those for psychiatric outpatients. Three groups reported rates of about 50%.[36, 46, 53] One interesting exception was a study done by Lief and Lief in a psychiatric outpatient clinic, where the dropout rate was a low 6% (with less than 5 sessions=dropout).[41] Of special significance regarding this latter study, is that all applicants were carefully screened to exclude psychopaths and other "poor risks." The subjects were mostly (85%) between the ages of

17 and 35, 98% were white and 20% were medical students. These factors make this population a highly select one and restrict the generalizability of its findings.

In summary, the extent of variation among previous research ventures makes interpretation and comparison of their findings difficult. Although several of the parameters we shall employ in delineating dropout characteristics will be derived from previous dropout studies, the basic differences, especially those related to definition of the phenomenon, should be borne in mind and will undoubtedly limit the interpretation of our own results.

RELATIONSHIP OF DEMOGRAPHIC CHARACTERISTICS TO DROPOUT

From the available literature, one gleans only two or three demongraphic variables which seem to be repeatedly and significantly correlated with premature termination from outpatient psychotherapy and counseling.

Neither age, sex nor marital status seemed to be significantly related to dropout from an outpatient clinic according to Frank, Gliedman et. al.[14] Another group also found age to be a non-significant variable; however, they did note that males tended to stay significantly longer.[47] Heilbrun, working in a college counseling setting, found age to be non-significant; however, the range of ages of his subject group was obviously limited.[23, 24, 25, 26] Although Lorr et. al. also found marital status of no significance, they did find that both race and religion were significantly predictive of dropping out.[42] Specifically, they noted that black patients tended to terminate,

while Jewish patients tended to remain in therapy. Bailey et. al. on the one hand, found that religion was a non-significant variable while Rosenthal and Frank found race to be significantly related, with the "remainer" rates' being twice as high among white patients (60%) as with blacks.[5, 47]

In performing our twelve-month retrospective review it was possible for us to examine a dropout population of greater similarity to our own. In so doing, we noted that neither age, sex, nor marital status correlated significantly with premature termination from the E.T.U. outpatient program. There was a slight trend for patients between the ages of 21 and 30 to have a greater liklihood of dropping out; however this was non-significant ($p<0.10$) Owing to a lack of data, the relationship between dropout and religion could not be evaluated in this review.

In contrast to Freud who thought that patients who usually dropped out of therapy were the psychotic ones[56], most studies have shown that diagnosis in itself is not a significantly important variable in predicting premature termination from therapy.[5, 42, 47] Several authors chose to administer the M.M.P.I. and found some consistent and inconsistent trends on the clinical scales among their patients who dropped out of therapy. The most constant finding was an elevation on the Pa (paranoia) scale noted in three different studies.[58, 45, 34] However, Taulbee noted that male "remainers were higher not only on the Pa scale, but on the scales for depression, hysteria and schizoid personality as well.[59] In a non-M.M.P.I. study, Hiler noted that remainers tended to be more phobic,

depressed and obsessive, but not significantly so.[31]

Interestingly, the E.T.U. patients of the twelve-month review very definitely demonstrated a relationship between premature termination and diagnosis. Diagnosis in this case was the therapist's designation and not independently determined. A diagnosis of psychosis (including acute, chronic and incipient schizophrenia) was predictive of a patient's "remaining" in therapy, where as a diagnosis of neurosis or neurotic depression was predictive of his dropping out ($p<0.01$) (see Table 1) A patient with any other diagnosis had an equal chance of dropping out or remaining.

The two demographic features which were most consistently related to patients' leaving therapy against the therapist's wishes, had been socioeconomic class and highest level of education attained. It appeared that subjects of lower socioeconomic class tended to dropout from outpatient psychiatric services more frequently than middle-class patients.[33, 4, 16] This trend was found to have predictive significance.[37, 14] In an interesting study on persuasability and dropout, Imber et. al. found that lower socioeconomic class patients who scored low on "persuasability" (as measured by a "sway" test) had the greatest tendancy to dropout and middle-class patients who scored high on persuasability had the lowest dropout rates.[37]

Unfortunately, few of the studies looking at social class gave their criteria for categorizing patients, nonetheless, some authors looked at occupation and income, separately. Although Bailey et. al. found occupation to be non-significant

with respect to dropout,[5] several studies did note a positive, though not significant, relationship between less skilled, less professional occupations and dropout.[58, 48, 42, 14] The second two of these latter four studies also found that lower income was predictive of dropout.

Because of the nature of the variable, namely that it deals with perseverance in a two-way interpersonal interaction, education was the one demographic characteristic which would seem to be most relevant to the issue of persistence in therapy. Understandably several researchers looked for a relationship and most agreed in their findings. Bailey et.al., Sullivan et. al., and Rosenthal and Frank all found that dropouts had completed significantly fewer years of education than remainers.[5, 58, 47] The second of these three studies went as far as noting that education was the most effective single variable with which to predict dropout. Other authors noted the same trend.[4, 48, 33, 42, 14] Heilbrun was the only one to find that education was an unimportant variable; however, once again, his subjects were college students in counseling and showed little variation on this variable.

For lack of data, we were not able to analyze our twelve-month review E.T.U. population for social class; however, specific plans for gathering this information for the subjects in this study, were made. Information regarding education of those patients in the twelve-month retrospective review was available for all but 49 of the 295 E.T.U. outpatients. This 49 represented 14% of the dropouts and 17% of the remainers in the group of 295. There was no reason to suspect that these patients, for whom education data was not identifiable, were

any more than a random group. When viewed from the standpoint of high school graduation, it was noted that those who had attained less than this level by the time of admission to E.T.U. had a significantly greater liklihood of dropping out than those who had graduated from high school. ($p<0.05$) No other, more specific, relationship between education and premature termination was found to exist.

One last variable studied in our retrospective review which was not mentioned in any of the dropout literature, was suicidal potential. Unfortunately, data concerning this variable was obtainable for only 68% of the E.T.U. outpatients. Of the 32% for whom there was no information, a somewhat disproportionate number were dropouts. The reason for this was not apparent. Thus, although no significant relationship was noted between suicidal behavior and dropout, the comparison was not a valid one. It will, therefore, be interesting to re-examine this issue in the present study where we can assure that complete statistics will be available.

VARIABLES EXAMINED IN PAST RESEARCH WHICH SHALL NOT BE FOCI IN THE PRESENT STUDY

Of the many seemingly important issues influencing dropout, one that seems to have been studied somewhat extensively is that of patient motivation and "appropriateness" for therapy. However, according to Levitt there were not significant differences in motivation between dropouts and remainers.[40] Rosenthal and Frank also looked at the question of motivation

and found no significant relationship to patients' persistence in therapy.[47] Interestingly, they did find that the association between motivation, as judged by the rating of a psychiatrist-supervisor who discussed and sometimes saw the patient together with the medical student who did the initial interview, and improvement, as judged by the patient's resident therapist at the time of discharge, did approach significance ($p<0.06$). Those with the least motivation improved the most but did not necessarily stay in therapy the longest.

A patient's success and persistence in therapy has often been discussed in light of his "psychological mindedness" and general insight. Heine and Trossman working in a psychiatric outpatient clinic, concluded that "faith and hope" in psychiatry is non-contributory to the success of a therapeutic relationship and threw doubt on the fact that insight, that is to say acceptance of a psychological basis for discomfort was important for continuance in therapy.[28] On the other hand, in a study with college student subjects, Heilbrun found that the more psychologically minded a student appeared, (as rated by one of the California Psychological Inventory scales) the significantly greater were his chances for dropping out of counseling.[25] Another venture, with psychiatric outpatients pointed out that the reasons patients gave for remaining in treatment (i.e. self modification verses situational assistance) bore no relation to how long they remained in treatment.[14] Thus, it seems as though little predictive value lies in knowing the degree to which one looks at psychological evaluation as a means of exploring the basis of one's problems.

Another area in which interest has been focused in an attempt to learn more about the dropout issue, is that of communication between patient and therapist. Hiler showed that remainers in therapy scored higher on the verbal subscale of the Wechsler-Bellevue Intelligence Test than did dropouts.[30] Three other studies reaffirmed the idea that facility in communication may bear some relationship to persistence in therapy.[39, 48, 54] Affleck and Mednick, using Rorshach tests, noted that abrupt terminators were characterized by limited verbal productivity and "avoidance of the expression of ideas dealing with human activity."[2]

Several other variables which were tested and not found to be significantly predictive of dropout were: 1- initial symptoms, complaints and discomforts as determined by Frank et. al.'s Discomfort Scale[14] and by therapist ratings;[28] 2-patient "maladjustment" as judged by L'Abate's Maladjustment Index,[34, 36] and by Sullivan et. al. using Pa and A scales of the M.M.P.I.;[58] 3-treatment frequency, length of each therapy session and type of treatment (i.e. group versus individual) according to Lorr et. al.;[42] however, Frank et. al. found higher percentages of dropouts in group therapy than in individual;[14] and 4- the sex, profession and experience of the therapist[42, 31, 58] Baum on the other hand found that the therapists with the least experience, had the poorest record for keeping patients in therapy.[7] Data concerning the degree of therapist experience shall be available in the present study and although there shall be no specific hypothesis put forth regarding this issue, it will be interesting to see if any trend is identifiable.

RELATIONSHIP OF NON-DEMOGRAPHIC CHARACTERISTICS TO DROPOUT

Besides the specific findings regarding the demographic characteristics of dropouts, past research has discovered certain qualities and personality variables which have proven important in examining and predicting the dropout phenomenon. Both patients and therapists have been assessed on various different traits and behavior patterns; however, what in all liklihood may prove to be more significant will be how the respective characteristics interact and compliment each other in such a way as to minimize the incidence of dropout.

a) Anxiety:

One factor which consistently seemed to be associated with persistence in therapy was that of anxiety as manifested, or at least admitted to, by the patient. The general agreement seems to be that people remain in therapy if they feel distressed or uncomfortable.[54, 67] Lorr et. al., working with VA psychiatric outpatients, found that dropouts scored significantly lower on a sub-test of the Taylor Manifest Anxiety Test.[42] These results were duplicated using a similar population.[44]

In two studies in which patients were administered the M.M.P.I. (and in the latter case a special "A" scale measuring anxiety) and rated for anxiety on the basis of their scores on the Pa and A scales, conflicting results were obtained.[59, 58] Taulbee, the first author, found that of the 85 psychoneurotics studied, those who remained in therapy scored significantly higher on

anxiety than did dropouts; however, Sullivan et. al., in the second study, found that it was the dropouts in his group of 131 patients who scored significantly higher on anxiety. Interestingly when Sullivan's group extended their approach to include two other groups of patients with 43 and 94 subjects respectively, his finding regarding anxiety no longer showed significance, nor would the combination of all three patient groups, when looked at as one sample, lend support to his initial finding. Several other authors lent even further support to the hypothesis that dropouts suffer, or at least admit to, less anxiety than remainers.[32, 15, 47]

From the research cited above, one gets the impression that anxiety is at least one factor significantly related to a patients' persistence in therapy. Whether the association is causal or merely secondary is not yet clear. If it were causal one might expect that with low anxiety, the patient feels less need for therapy and terminates prematurely. This hypothesis at least in part, rests on the premise that anxiety is a manifestation of the tension prerequisite to keeping someone in therapy. Instead, however, one may construct the hypothesis to say that with increased anxiety, a patient feels sufficiently threatened so as to remain in the therapy situation as long as possible. In such an instance, the anxious patient would be deriving tension-relieving comfort and security from: 1-the therapy sessions and/or 2-being out of the environment which itself may have been responsible for the anxiety with which the patient presents in the first place. In the latter case, the refuge which

outpatient therapy would provide could be only intermittant, but gratifying, nonetheless.

Instead of being causal, the relationship between anxiety and premature dropout were merely of secondary association, one would derive different hypothses. For example, it would be possible to say that the patient who is less aware of (and therefore denies) his own anxiety will also be the one who is unaware of the need for remaining in therapy and terminates without the advice and consent of his therapist. Such a hypothesis would assume that either the patient is actively and consciously denying the anxiety he is experiencing, or that the measure being used to detect and assess it is not sufficiently sensitive or "fake-proof." An alternative proposal which might be offered to explain a secondary association would be that the patient who for other reasons chooses to terminate therapy, will understate the anxiety he feels in order to justify to himself, or his therapist, his desire to dropout. The fact that most studies have measured anxiety at a point in the patient's course at which he has probably not yet made a decision about leaving against advice, suffices to make the latter hypothesis improbable.

Thus far, the tension-relieving, causal hypothesis seems the most satisfying and appropriate one in light of the subjective impressions relayed by those E.T.U. staff members who have followed patients in the outpatient program. The present study will attempt first, to duplicate former results by establishing an inverse relationship between a patient's

level of anxiety and his tendancy to terminate outpatient therapy against his therapist's wishes. Secondly an attempt will be made to delineate the nature of this relationship more fully by exploring the extent to which the therapist experiences anxiety and what effect this may have on keeping the low anxiety patient in therapy. This latter approach shall provide a better understanding of how anxiety emanating from the therapeutic relationship, itself, affects dropout. If our hypothesis is correct, one might expect those patients who are more anxious to enjoy greater relief of tension with a therpaist who scores low on anxiety, and, therefore, dropout less often, than they would with an anxious therapist. It will, in addition, be interesting to see whether other therapist traits or behavior such as dominance or critical-role expectation affect the tenure of low anxiety patients and in what fashion.

b) Dependency:

A second variable which one would expect to play a significant role in the therapeutic interaction, is that of an individual's dependency. Several studies have looked at this variable and, more specifically, its relationship to premature dropout. Although most investigators found that dropouts tended to be more independent than those who remained in therapy, one study rated patients on approval-dependency and found that those who were rated highest also dropped out of therapy sooner.[56] However, one important point regarding this latter project was that although the more dependent

patients were no different from a diagnostic standpoint than independent patients, the former were rated by therapists as being more defensive and disorganized, and less personally liked and satisfied with the progress of therapy. With dependent patients distinguishable on more than one characteristic, the results of this study became less useful. One questions whether it was actually a patient's dependency alone which caused him to drop out, and wonders whether his defensiveness and dissatisfaction with therapy were the more instrumental factors. It would be necessary to control for each of the characteristics these authors had found to be related to dependency before conclusions can be drawn about such patients being more dropout prone. In addition, it would be quite valuable to examine the therapist's manner of response to the patient's dependent behavior.

The majority of investigators arrived at conclusions contrary to those of the above mentioned study. One group used a 52-item sub-scale measuring "counseling readiness" (their proven equivalent of tendancy to stay in therapy) and the California Psychological Inventory measure of self acceptance among a group of students in a counseling setting.[25] Heilbrun, author of this study, found that males who scored higher on self-acceptance (i.e. were more independent in thought and action) tended to dropout more. Horton and Kriauciunas on the other hand, looking at the same question with a similar population and using Leary's Indices (special M.M.P.I. scales) as their measure, showed that their expectations of dropouts' being more independent ("help-rejectors") and remainers more dependent ("help acceptors") did not hold true.[34]

One author administered the M.M.P.I. to only psychoneurotic patients and found that those who remain in therapy (versus dropouts) are more dependent individuals with a "greater need for affection and self-acceptance.[59] Zuckerman and Grosz noted that patients who scored high on a "sway test" measuring persuasability, also scored high on dependency (as judged by autonomy, deference and succorance scales of Edwards Personal Preference Test).[68] And since swayers have been shown to have a tendancy to stay while non-swayers are not prone to either dropout or remaining[14, 37, 68] there is a suggestion that dropouts tend to be less dependent. With clients in counseling, two other investigators also used the three pertinent E.P.P.S. scales as a self-descriptive measure of dependency.[29] In addition, they used a situational test to measure overt (behavioral) dependency and a picture impressions test to rate the client's attraction for his therapist. Their findings indicated that the more dependent were clients pre-therapy the more attracted was the client to the therapist. Although one might extrapolate to say the dependent client, being more attracted to his therapist, would dropout less, this study neglected to look at the question of dropout specifically.

One of the few undertakings which attempted to look at the relationship between a specific patient-therapist interaction and premature dropout concerned itself with patients' dependency and therapists' response to it.[66] In this study, three raters scored patients on a number of dependency-related criteria (i.e. approval-seeking, help-seeking, company-seeking,

information-seeking, demand for therapist initiation) and also scored the way in which the therapist reacted to the various dependency manifestations. What was found was what one might predict. If during the initial treatment phase, expressions of dependency by the patient were reinforced or "approached," the patient tended to remain, whereas those cases in which such expression were "avoided" resulted more often in the patient's dropping out. In this context it will be interesting to see if patients in our own study who score high on dependency, have a lower dropout rate when paired with a nurturant therapist than when paired with a critical therapist.

Another study which also looked at dependency from the standpoint of a therapeutic interaction rather than of isolated characteristics, involved college students in counseling.[24] The latter investigation found that although dependent male students tended to stay regardless of therapist, female students who were more dependent would tend to stay if their counselor was of average "dominance," but would tend to dropout with counselors who scored high on dominance. Steps to duplicate these sex specific findings shall not be undertaken in the present study.

c) Dominance:

The question of patient dominance as an isolated variable has been examined as well. In the study just cited for dependency, male dropouts were noted to be significantly more dominant than male remainers.[24] In a later study by the same author,

male dropouts again tended to rate higher on dominance - related variables (self acceptance, self worth, independent thought and action).[25] Again, in 1965, Heilbrun pointed up similar findings, but without sex differences.[26] In this latter venture he administered the "need scales" from the Adjective Check List and found "dominance" to be one of the personality variables which would differentiate remainers and dropouts, in that dropouts, regardless of sex, scored higher on dominance.

Taulbee, in his work with the M.M.P.I. and Rorshach tests given to a psychoneurotic patient population, noted remainers to be more self-doubting, and less dominant than dropouts.[59] Horton and Kriauciunas on the other hand found no difference on M.M.P.I. scores of dominance and submission between their adolescent counselee dropouts and remainers.[34]

Related to the issue of dominance and not clearly separate from it, is that of self-dissatisfaction and self-abasement. If remainers scored lower on dominance one might predict they would also more commonly manifest personal dissatisfaction than would the more dominant dropout. One psychiatric outpatient facility noted this to be the case on two different occasions.[48, 42] Heilbrun came to similar conclusions, but again only for male patients.[24] Other investigators, however, using the M.M.P.I. results of a psychiatric outpatient population, noted dropouts in their group as rating lower on ego strength than remainers.[58]

Whether the above described relationship between a patient's dominance and his tendancy to dropout of therapy prematurely stems from the fact that only the self-assured, self-assertive

patient would be in a position for transcending the wishes and desires of his therapist, remains to be proven. It may instead become evident that the therapeutic relationship is such that the dominant patient finds it too restricting, limiting or personally imposing for him to remain. To look for a direct association, especially in view of the results which have been gleaned thus far, seems to be a narrow and less fruitful approach, than would be one which would examine the dominant and submissive patient and how their tendancy to remain in therapy is influenced by the degree to which their therapist's behavior and personality compliment his own. Although we might hypothesize that the dominant patient, who should be more uncomfortable in the therapeutic situation and bold enough to arbitrarily terminate it, would be more likely to remain if he were paired with a less dominant therapist, it may evolve that this is not the case and that possibly other therapist qualities play a role.

d) Authoritarianism:

Another personality characteristic which would be interesting to examine in its association with dropout, is that of "authoritarianism." In his work with the "Terminator-Remainer Battery," McNair found that those patients who terminated prematurely also endorsed authoritarian social attitudes and opinions significantly more than remainers.[44] Another author, using the Edwards Personal Preference Schedule noted that dropouts scored higher on the "order" scale than did remainers.[61] The only researchers to note that remainers were significantly less hostile to authority than dropouts,[48] later found, with

a similar group of subjects, the opposite to be the case.[42] It may be that the environment created during most psychotherapy sessions, because it depends on the patient's assuming a certain degree of responsibility for his own improvement and development and because of its usual lack of rigid guidelines, is one for which a patient with strong authoritarian beliefs has low tolerance. We would, therefore, expect to see that those authoritarian patients who do not dropout of therapy are most likely to have therapists also scoring high on an authoritarianism scale.

e & f) Impulse Control and Hostility:

Two other variables which have been examined in the past and which shall also receive our attention are those of impulse control and hostility. Regarding the former, three major studies noted as part of their results that those who terminated prematurely were more aggressive, assaultive and acting out. In addition, they were more undependable and impulsive than were remainers.[32, 48, 42]

As for hostility, two different research ventures using the same measure of hostility, namely the M.M.P.I., came up with opposite results. Horton and Kriauciunas found that remainers scored significantly lower on hostility than did terminators.[34] Taulbee, on the other hand, noted the remainers to be more moody and hostile and to nurse more grudges.[59] The major difference between these two studies was that the former used an adolescent population, while the later used a more age-varied psychoneurotic patient population. In this context, the present study shall propose a hypothesis regarding hostility on the basis of the second study because of the greater similarity of

its subject group to our own. One author, who examined therapist characteristics, noted that those clinicians who appeared warm and friendly, held in therapy those patients who were more unproductive on the Rorshach Test (a criterion found to correlate well with tendancy to dropout of therapy) than did the less friendly more hostile therapists.[31] In 1968, Bandura noted that in general therapists avoid hostility directed against themselves; however, those who express their own hostility in direct forms and who display low need for approval were more likely to permit and encourage a patient's expression of hostility.[6]

The present study shall, therefore, limit itself to looking to see if patients scoring high on hostility or impulse control exhibit a lower incidence of dropout, and whether being paired with a low hostility or low impulse control therapist decreases the chances of a low hostility or low impulse control patient's, respectively, dropping out.

RELATIONSHIP OF THE MUTUALITY OF PATIENT AND THERAPIST EXPECTATIONS TO DROPOUT

An area of interest which has been the focus for a number of dropout studies, is that of the mutuality or congruence between patients' and therapists' expectations of the therapeutic interaction. The several investigators who explored this issue came up with varying results as to whether or not the issue had any bearing on dropout.

One group, using a lower socioeconomic class, psychoneurotic patient population, found no significant relationships between

dropout and: 1-patient's perceptions of their problem and how they could be helped by therapy; 2-the degree of concordance of patient and therapist expectations; and 3-the therapist's expectations concerning a patient's "appropriateness" for or ability to benefit from psychotherapy.[55] Gliedman et. al., using four sessions as the cut-off point to distinguish dropouts from remainers studied the mutuality of expectations between a group of 91 psychiatric outpatients and their therapists.[17] They noted that congruence between a patient and his therapist on what general incentives lay ahead in the psychotherapy sessions to take place, did not influence the patient's persistence in therapy. In addition, expectations, in terms of incentives, were equally unrelated to the improvement of or the extent of persistence beyond the fourth session of remainers. It was the speculation of the authors that remaining in treatment depended primarily on whether doing so favorably influenced the equillibrium of the patient's pattern of living at the time.

Goldstein, in a study done in 1960, showed patient expectations to be unrelated to dropout.[18] However, he did find that therapist prognostic expectancies and combined patient and therapist expectancies did relate significantly and positively to duration of therapy. Heine and Trossman found that only certain patient expectations showed a direct relationship to continuance in therapy.[28] That is to say, using six sessions as the cut-off between dropout and remainer status, they noted that "neither the patient's presenting complaint nor his stated expectations regarding the efficacy of psychiatric treatment, bore any

relationship to continuance in therapy." However, the patient's expectations regarding the nature of psychiatric treatment and the means by which this treatment would be conducted were highly related to continuance. Heine and Trossman did not, however, examine the actual mutuality issue, other than to say that "continuers conceptualized the experience in a manner more congruent with the therapist's role image and were, therefore, in one sense more gratifying to the therapist." [28 page 278] Friedman et. al. further substantiated this relationship between duration of therapeutic contact and the degree of congruence of participant expectancies regarding purposes and methods of their imminent interaction. [20 page 82]

Despite the equivocal nature of the above findings, the present study shall set out to test, the hypothesis that: a patient whose expectations of his therapist's behavior coincide with the therapist's expectations of his own behavior, will dropout of therapy less than when their expectations are polarized. The measure which, because of its being used in past dropout research and its ease of administration, would be of most use in our setting, is that used by Goldstein and Heller. [18, 21] This measure, the P.E.T.I., will be more fully described in our methodology section. The items for this questionnaire were derived from an investigation by Apfelbaum, carried out in a university psychiatric outpatient clinic. [3] One hundred patients were administered Q-sorts and the M.M.P.I. and a cluster analysis of Q-sort responses, designed to measure patient's pre-therapy expectations regarding the personality of their prospective therapists, was carried out. Three relatively independent clusters or dimensions of patient role expectations were revealed: nurturant, model and critic expecting. Nurturant-expecting patients were described as expecting a "guiding,

giving, protective therapist who is neither businesslike, critical nor expects his patients to shoulder their own responsibilities." Model-expecting patients expected" a well-adjusted, diplomatic therapist who neither judges nor evaluates his patients and who plays the role of a very permissive, listener." Critic-expecting patients expected "the therapist to be critical and analytical, to want his patients to assume considerable responsibility and, further, to be neither gentle nor indulgent."[20 page 57] Of his 100 patients, Apfelbaum noted a dropout rate of 33%, a figure comparable with that of other studies. (see above) In addition he found that model-expecting patients evidenced significantly less dropout. No significant differences emerged, however, between "nurturants" and "critics". He did observe, nonetheless, that nurturant-expectors managed to be seen more frequently than critic-expectors.

The N, M and C items delineated by Apfelbaum and organized into the P.E.T.I. by Goldstein, were validated and examined for their relationship to personality correlates.[21] Polarity and independence of each of the three categories was established. It was also evident from the latter study, that nurturant-expecting therapists saw others as more dominant and forceful while model-expecting patients were more defensive about admitting psychological problems and less anxious and dependent. This investigation did not, however, differentiate patients from the standpoint of dropout.

RELATIONSHIP OF PATIENT AND THERAPIST A-B STATUS TO DROPOUT

Of those objective measures used in the past for exploring the issue of differential matching of patient and therapist, that

of A-B status has proven to be one of the most extensively used and interesting of all. To date, no study has elected to employ this measure in investigations delving into the problem of outpatient dropout.

When initially conceived, the A-B classification was used by Whitehorn and Betz as an arbitrary designation for the differential success of a group of 14 psychiatric residents working with schizophrenic patients in the psychiatric outpatient clinic of a large medical center.[64] Success was understood to mean a high improvement rate as judged by a retrospective evaluation of: 1-the therapist's, the psychiatrist-in-chief's and the senior resident psychiatrist's appraisals, and 2-four "objective" criteria (disposition at discharge, increased participation in social relationships with other patients, increased participation in clinic activity programs and changes in behavior-chart ratings). The therapists with the highest improvement rates (upper 20%) were arbitrarily designated "A", while the 20% with the lowest improvement rates were designated "B". The success enjoyed by "A" therapists was attributed to their ability to understand, gain the confidence of and develop a meaningful, actively involved relationship with the 100 middle and upper class schizophrenic patients who were treated.

Two years later, the same authors administered the Strong Vocational Interest Blank (S.V.I.B.) to 35 therapists (including some of those who took part in the 1954 study) whom had already been designated A or B on the basis of their improvement rates with patients.[10] They discovered eight occupation profiles on

which A's and B's differed significantly. In a subsequent examination A's were noted as scoring significantly higher for the lawyer and CPA categories while B's scored higher for printer and mathematics - science teacher.[65] Those twenty-three items which significantly differentiated A's and B's were cast into two small scales. Using the latter, the authors then were successfully able to predict improvement rate.

In 1962 McNair et. al. examined the improvement rates of therapists who had been designated A or B according to their differential performance on a 23-item A-B scale derived from the previous investigations but who worked with non-schizophrenic, psychoneurotic patients.[43] All of the latter individuals were males, and from the lower and middle socioeconomic classes. Interestingly, McNair noted B therapists as having the best improvement rates with these non-schizophrenic subjects. A year later the same authors looked to see if therapist A-B designation had any effect on duration of therapy but noted none.[44] Unfortunately, patients in the latter study were not differentiated according to diagnosis, making this study-the only one semi-related to the dropout issue-of limited value. Nonetheless, as Betz latter pointed out, A and B therapists may have differential sensitivity to "avoidance" (schizoid) behavior and to "turning against self" (neurotic) behavior, most likely yielding optimal degrees of "fit" between such therapist and patient characteristics.[9]

The last major study to be discussed here, was especially significant in its being the only attempt to administer an A-B scale to patients rather than therapists.[8] In it, 68 male

patients, in a university health service setting, took the A-B scale and were rated by a group of therapists as to their symptom patterns. Of interest was the fact that they noted A patients as presenting neurotic patterns while B patients presented schizoid patterns. This suggested the possibility of improvement's, and by chance dropout, being positively related to reciprocal rather than mutual patient-therapist performance on the A-B measure.

In the present study, an attempt shall be made to discern whether the described relationship between therapist A-B status and patient affects success of the therapeutic relationship as measured by dropout rather than improvement rates. In addition, the extent to which the reciprocal A-B matching of patient and therapist affects dropout shall be examined.

HYPOTHESES

Individual Characteristic Variables

I. A patient's age, sex, marital status, race and religion are not predictive of dropout.

II. Patients of lower socioeconomic status, will dropout of therapy more so than patients of high socioeconomic status.

III. Patients with less than a high school diploma will dropout of therapy more so than patients who have achieved this level of education.

IV. a) Patients with a diagnosis of psychosis (including latent schizophrenia) will dropout of therapy less so than all other patients.

b) Patients with a diagnosis of neurosis (including neurotic depression) will dropout of therapy more so than all other patients.

V. A history of suicidal ideation or behavior shall not influence a patient's persistence in therapy.

VI, a) Patients who rate low on anxiety will dropout of therapy more than those who rate high on this variable.

b) Patients who rate high on dependency will dropout of therapy less than those who rate low on this variable.

c) Patients who rate high on dominance will dropout of therapy more than those who rate low on this variable.

d) Patients who rate high on authoritarianism will dropout of therapy more than those who rate low on this variable.

e) Patients who rate high on hostility will dropout of therapy less than those who rate low on this variable.

f) Patients who rate high on impulse control will dropout of therapy less than those who rate low on this variable.

Interaction Variables

VII. A patient whose expectations of his therapist's behavior coincide with the therapist's expectations of his own behavior, will dropout of therapy less than when their expectations are polarized.

VIII. a) Patients who rate low on anxiety will dropout less with critical or dominant therapists than with nurturant or dependent therapists.

b) Patients who rate high on dependency will dropout less with nurturant therapists than with critical therapists.

c) Patients who rate high on dominance will dropout less when paired with a therapist who is nurturant or low in dominance than a therapist who is critical-expecting or dominant.

d) Patients who rate high on authoritariansim will dropout less when paired with a therapist who rates high on authoritariansim than with a therapist who rates low on this variable.

e) Patients who rate low on hostility will dropout less when paired with a therapist who rates low on hostility than with a therapist who rates high on this variable.

f) Patients who rate low on impulse control will dropout less when paired with a therapist who rates high on this variable than with one who rates low.

IX. a) Psychotic patients who are paired with "A" therapists will dropout of therapy less than those who are paired with "B" therapists.

b) Neurotic patients who are paired with "A" therapists will dropout of therapy more than those who are paired with "B" therapists.

c) "A" patients who are paired with "B" therapists and "B" patients who are paired with "A" therapists will dropout of therapy less than those who are paired to a therapist of identical A-B status to their own.

METHODOLOGY

RETROSPECTIVE DEMOGRAPHIC REVIEW

In preparation for this study, we carried out a systematic review of all the vital statistics available on E.T.U. patients admitted during a 12-month period, July 1969 to June 1970. This included only those E.T.U. patients who were assigned E.T.U. as their primary source of outpatient therapy following the crisis-induced hospitalization. The majority of the information, including age, sex, race, marital status and diagnosis was obtained from the E.T.U. log book, in which a record of all admissions was kept. Since the log book did not contain many of the patients' diagnoses, nor data about education or suicidal behavior, a purusal of charts in the record room was made. Although a number of old records were incomplete or absent, a major portion of the information in these three categories was determined.

It was evident in the description of our population above, this review gave us a basis for comparing our subjects with those patients of an earlier period. In addition, it provided a bridge of information between the Weisman review of all E.T.U. admissions for the first two years of the unit's existence (the only other comprehensive review of statistics) and our own group.

Those patients during the 12-month period who did not keep appointments and who dropped-out of the outpatient, follow-up program were noted in the unit log book. It was thus possible to compare our own dropouts to those of past years. Unfortunately, one major limitation, quickly became evident. This resulted

from the fact that specific criteria for classifying someone a dropout had not been defined in the past. In most instances the designation was made by the staff supervisor of the outpatient program. He would routinely ascertain from team leaders, the current status of all the patients being followed in the 30 day program. Whenever it was brought to his attention that a patient had "been missing appointments and had terminated therapy against the wishes of his team leader," the supervisor would make a notation in the log book. An actual account of the number of outpatient appointments made kept, broken, and cancelled had not been recorded. In addition, upon examining the old records, it was noted that in several of the 296 cases, a patient who had actually broken appointments and terminated without his therapist's advice and consent, had not been designated a dropout in the log book. Because information regarding appointments and termination was available in only certain records we relied primarily on the log book for dividing this review population into dropouts and remainers. Undoubtedly, for the reasons just delineated the dropout rate during that 12-month period was an underestimate if judged from the standards that have been used in this study. Nonetheless, and especially in light of the fact that hardly any research into the dropout issue on a crisis intervention unit had been present in the literature, this review provided a specific though somewhat limited foundation from which to plan and compare our present venture.

GENERAL PLAN

PHASE I - The basic structure of the present study is most easily divided into three major parts. First will be a comparison between dropout and "remainer" subjects on various demographic and patient specific characteristics, as well as on the demographic traits of each patient's respective therapist.

With regard to the latter, these therapist traits shall be treated as individual variables of the patients themselves, rather than in relation to a separate sub-population (i.e. the therapist sample).

PHASE II- The second portion of our plan shall concern the comparison of dropout and remainer subjects on: a) their own and their therapists' expectations of the therapy situation; and b) their own and their therapists' scores on a questionnaire testing six different personality variables - impulse control, anxiety, authoritarianism, hostility, dependance and dominance. The selection of these criteria was largely a result of previous findings in dropout research as outlined in the review of the literature above.

PHASE III A & B - The third and final segment of our approach shall direct itself to testing two simple systems of matching patient with therapist. The first system shall entail looking at our population for all possible combinations of three variables. The first variable shall be attendance status (i.e. dropout or remainer) The second shall be patient therapy-expectation or personality characteristic. The third variable shall be therapist therapy-expectation or personality characteristic. The therapy expectation scores and personality variables and scores used here shall be identical to those compared individually with attendance status in the second portion of the plan. Thus because there are three therapy expectation scores and six personality scores (one for each of the six personality traits listed above), eighty-one combinations shall be possible.

The second system of matching patient and therapist shall in a sense be an accessory approach to our central goal. It shall involve exploring the expected relationship between patient diagnosis, both patient and therapist scores on a vocational interest scale and how the differential matching of these affects the "success" of the therapeutic interaction. Our parameter for success shall be the preservation of the therapeutic relationship (i.e. the avoidance of its ending because of dropout.) Although this vocational scale has been employed on numerous occassions, dropout has never been used as the parameter of success; therefore, hopefully our efforts shall begin to broaden the understanding and range of use of this tool.

MEASURES (see Appendix 115)

A booklet of three questionnaires was administered to every staff member working at least one day on the unit and every individual admitted to the unit, during the four month time interval. Although the third of the three measures had not been examined for test-retest reliability, there was little reason to suspect the point in time at which they completed the questionnaire would affect their choices. The content of the questionnaires was identical for both therapists and patients. The only way in which the booklets differed was that the patient booklets had a header sheet with a paragraph over the signature of the director of E.T.U. This paragraph very briefly outlined the general purpose of the questionnaires and guaranteed confidentiality. In addition, the

instructions for the therapy-expectation test were worded in different ways to be more specifically-appropriate to patients and therapists, respectively. However, the overall content of the two sets of instructions was basically the same, in that both aimed at assessing the expectations of the therapist's behavior held by patient or therapist.

a) The first questionnaire in each booklet was a modified version of the Whitehorn-Betz A-B Scale, a vocational interest test (see Appendix-p 116). Because of its brevity and simplicity, it was placed first in the booklet. The 19-item version used was derived from the original Whitehorn, Betz studies[9] and the item analytic work of Schiffman, Carson and Falkenberg.[49] This version included only those items which correlated best with the total score on the Kemp[38] modification of the original Whitehorn-Betz scale. Thirteen of the items are identical to those published by Lorr and McNair[69] in a 15-item scale which showed an internal consistency of 0.91.

b) The second measure included in the booklet was either the Patient's Expectancy Type Inventory (P.E.T.I.) or the Therapist's Expectancy Type Inventory (T.E.T.I.) for patients or therapists respectively. As we have just noted the only difference between these two versions was the wording of the instructions. Both were taken directly from Goldstein and Heller[19] The latter authors selected the items for the test from a list in Apfelbaum's Dimensions of Transference in Psychotherapy.[3] They chose only those

which Apfelbaum's had found to be highly characteristic or highly uncharacteristic of the "nurturant "(N) , "model" (M) and "critic" (C) expectancy clusters. They then cast the items into a modified paired-comparisons format to form the P.E.T.I. The resulting measure contained 42 questions, each of which presented a pair of Apfelbaum's original items of which the subject was to chose the one which more accurately described his expectations of the therapist's role.

c) The third and final questionnaire in the booklet was a 42 item true-false test aimed at measuring patients' and therapists' anxiety, level of impulse control, authoritarianism, hostility, dependancy and dominance. Seven items for each of the six categories, taken from a number of different sources, were randomly arranged by the author. Relevant items, and clusters were selected at random from measures used and validated in Lorr et. al.'s dropout study,[42] and from the Edwards Personal Preference Schedule.[12] The latter was chosen as a source because it provided well tested reliable items for the variables we sought to explore. In addition, it had been used in its complete form, in two dropout studies.[61, 29]

Of the 42 questions, #'s 1, 12, 18, 22, 25, 32 and 37 were those measuring impulse control. All but #18 were taken from Lorr's "Terminator-Remainer Battery." The latter had been in part made up of those impulse control questions from a 39-item Behavior Disturbance scale (taken from a longer unpublished inventory devised by

Applzweig and Dibner) which Lorr found to correlate well with duration of outpatient treatment.[42] The 18th question was added by the author to bring the total number of questions to seven.

Anxiety was the variable common to questions #2, 8, 16, 23, 30, 36 and 42. Of these, all but the last two were again taken from Lorr's "Terminator-Remainer Battery". He in turn had chosen as his items, those questions from a 30-item version of the Taylor Manifest Anxiety Scale[60] which he found to correlate well with duration of outpatient treatment. Numbers 36 and 42 of our questionnaire, although not used by Lorr were taken from the Taylor Scale as well. They were selected from a list of those Taylor items found by Hoyt and Magoon,[35] to correlate very highly with a different criterion of anxiety. Thus these last two questions, again added to provide us with seven questions, had not been employed in previous dropout research; however, they had at least been shown to be reasonably reliable measures of anxiety.

Questions #6, 10, 13, 24, 27, 34 and 38 measured authoritarianism. All but #'s 10 and 27 were selected from Lorr's 21-item "Terminator-Remainer Battery". Lorr had noted these questions as being those from a 20-item F-scale taken from Adorno et. al.[1] which correlated best with duration of treatment. In the original format, these questions were to have the respondant indicate his degree of agreement with each on a four point scale. We modified the questions slightly so they instead could be answered in a true-false manner. Questions 10 and 27 were conceived and added by this author to provide a total of seven items.

The variable of hostility was represented by questions #3, 9, 15, 19, 26, 31, and 39. Since the measures of hostility used in previous relevant research[31, 34, 22, 42] were not felt to be easily applicable to our setting and population, a new measure was derived for this study. Questions 9 and 15 were taken from the Edwards Personal Preference Schedule.[12] They were selected from the "aggression" category on a listing of all the E.P.P.S. statements broken down by variable. Both statements were in a form which could be answered in a true-false fashion, even though the E.P.P.S calls for a different method of response. The other five questions were selected from Buss and Durkee's Hostility-Guilt Inventory.[11]

Questions #4, 7, 14, 21, 29, 35 and 40 of our true-false measure sought to assess subjects' dependency. Of these, #'s 4 and 14, #'s 21 and 35 and #'s 7 and 40 were selected from the autonomy, deference and succorance categories, respectively, of the E.P.P.S. Question 29 on the other hand was our own addition.

In summary, the third questionnaire in our booklet, though relatively concise, simple and inclusive of those variables we sought to explore, presented several obvious limitations. Foremost among these were the use of items untested for validity, the variety of sources, as well as the fact that several of the sources had not been used in dropout research before. The restrictions that this placed on the interpretation and comparison of our findings with those of previous studies should be borne in mind.

DATA COLLECTION - PROCEDURE

Therapist data: About two months prior to the time period of our study, the author briefly spoke before a majority of the staff members at one of the weekly Unit Meetings. It was explained that the study, which we were going to carry out was aimed at exploring the issue of dropout from E.T.U.'s outpatient follow-up program. Emphasis was placed on the fact that we would be primarily concerned with learning more about the effect of complimentary matches of patient and team leader on dropout, rather than about the relationship between certain therapist traits and dropout. A short description of the questionnaires they would receive and the way in which they would have to cooperate in the assessment of patient attendance, was made and several questions were answered. Those staff members who had not been able to attend this meeting were individually given an identical explanation by the author.

During the two weeks prior to, and three initial weeks of the study, questionnaires were handed out to all but two of the permanent therapist staff. The distribution was done by the director of E.T.U. or the author, and questionnaires were returned to the same two individuals or to the director's mail basket, within twenty-four hours. In addition booklets were similarly distributed and collected from the part-time, psychiatric residents within two weeks of their joining the unit. Questionnaires from the remaining two staff members, who though "permanent" were only on E.T.U. part of each week, were unfortunately not obtained until after the completion

of the study's time period." Although it would have been ideal to collect all of the therapist questionnaires simultaneously and prior to the onset of subject collection, this was technically not possible. Demographic information was personally ascertained from each of the therapists by the author.

Patient data: Questionnaire booklets were given to every new E.T.U. admission by one of the two full-time secretaries. Whenever possible this was done on the patient's second day of hospitalization, therefore, prior to the point at which he knew who his outpatient therapist would be. In most cases this was also before he knew who is inpatient team leader would be. In several instances, because of a patient's still being too confused or upset, or because the patient had been admitted on a weekend, the questionnaires were not filled out until the third or fourth day of hospitalization.

With the distribution of the booklets, the secretaries would give brief verbal instructions and clarify any question regarding the method of response. Patients were given as much time as they needed to complete all of the questions. In cases in which the secretaries noted an omitted or double response, the questionnaire was returned and the patient asked to make one selection.

The demographic information for each admission was collected by the two outpatient coordinators (a nurse and psych aide of the permanent staff). This was recorded in the unit log book. Information regarding past suicidal behavior or ideation,

previous history of psychiatric hospitalization and social class (computed according to the two-factor index of Hollingshead and Redlich) was obtained and recorded in a similar fashion.

A separate written record was kept by the author, of all those admissions who received the E.T.U. 30-day follow-up program as their post-inpatient disposition. At several intervals during the time period of the study and the month following its completion, the author met with each of the outpatient team leaders to obtain and record the number of appointments made, kept, cancelled and broken by each subject. Notation was also made whenever one of the patients was seen as a couple, family or in a home visit. As each subject completed his outpatient phase, his therapist was also asked whether termination had been with mutual agreement or against his wishes and whether the patient was to receive further outpatient therapy (or hospitalization) in some other facility.

SCORING OF QUESTIONNAIRES

Modified Whitehorn-Betz AB Scale: This test was scored in a fashion similar to that used previously for this version of the original measure.[49] For each of questions 1 through 13 to which the subject had indicated "like", and for each of questions 15 through 19 to which the subject selected "true or not sure", he was given one point. In addition, an answer of "indifferent" to any of questions 1,2,3, 5, and 6 or an answer of "false" to question 14 also earned the patient one point each. (see Appendix p 116). Thus a a patient could score anywhere from zero to 19. This method resulted in

high scores being equivalent to B status and low scores equivalent to A status.

P.E.T.I. & T.E.T.I.: These questionnaires, differing only in the wording of the instructions, were scored according to a key supplied by the original author (see Appendix.p 122). The test was, therefore, productive of three scores for each subject, measuring the degree to which that examinee expected the therapist to act in a nurturant (N) model (M) or critical (C) manner. Each of the two choices, for each of the 42 items, carried a certain value of N, M, and C. Thus, by examing each subjects selections, and adding up their N, M & C three total values were derived. These were then weighted according to specified instructions. Twenty points were then arbitrarily added to each of the N, M and C values to obviate negative scores and facilitate coding on I.B.M. punchcards.

Personality Ture-False Questionnaire: The author devised the system of scoring for this non-standardized test, such that each group of 7 questions, for each of the six variables (impulse control, anxiety, authoritarianism, hostility, dependancy and dominance) was scored as a unit. Each time a subject answered one of the questions in a group in a manner which positively manifested the variable being tested by that group, he received one point. In this way, every individual earned six different interger scores, each one ranging from zero to seven. A patient or therapist scoring 7 for impulse control would, therefore, be considered to rate highly on control while someone rating zero would be judged as highly impulsive.

In several instances despite efforts at prevention, subjects omitted or checked both choices of a given question. When this occurred, that question was scored as if it had been answered with the mean response to that item.

CRITERIA FOR DROPOUT

It became apparent from our review of the literature (see page 26) that the method used in previous research of comparing only the extremes of the spectrum of duration in therapy in order to distinguish those who "dropout" from those who "stay," would hardly be workable for our own population. The brief nature of the outpatient contact would provide too narrow a spectrum. In addition, although the outpatient period is generally about 30 days long, patients meet with their therapist with varied frequency, depending on the nature of their specific situation. Therefore, using the median number of appointments of the entire population as a criterion would not be valid or appropriate. It is for these reasons, that an empirical, somewhat arbitrary approach toward establishing dropout parameters was taken

The three criteria finally selected were:

a) any patient who cancels more than 50% of the appointments he and his therapist have scheduled, regardless of excuse. (cancellation was interpreted as a patient's communicating with his therapist, before a given appointment, a reasonable excuse for not being able to keep that appointment.)

b) any patient who breaks more than 33% of the appointments he and his therapist have scheduled, regardless of excuse. (a broken appointment was considered as one for which a patient did not show up nor notify his therapist beforehand.)

c) any patient who terminates against the wishes of, or without mutual agreement of his therapist regardless of appointments kept, cancelled or broken.

Any patient who fulfilled one or more of these three criteria was classified as a dropout. All other subjects in our population were then classified as remainers. In the few instances where a patient both cancelled and broke appointments, a cancelled appointment was counted as a fraction of a broken appointment according to the criteria percentages and a single "percent broken" value arrived at.

CODIFICATION AND STORAGE OF DATA

The demographic, patient related (i.e. suicidal behavior, previous hospitalization, diagnosis etc.), dropout related and questionnaire data for each subject was coded and keypunched onto a single I.B.M. card. The demographic statistics and questionnaire scores of each subject's team leader were similarly coded and keypunched onto the respective patient's I.B.M. card.

With the use of an I.B.M. card sorter, distributions of values for each variable were obtained. The latter distributions then

provided us with the information needed to combine or "lump" categories within each variable, as indicated. These "lumped" values were later accomodated by including the necessary transformation instructions with the computer input.

Since it was anticipated that the size of our population would limit the usefulness of the "raw" questionnaire scores in making our statistical comparisons, use was made of the distributions of scores. For each P.E.T.I. variable (N, M and C), for each of the six variables tested in the true-false questionnaire and for the A-B questionnaire result, a range of scores was derived. Each of these ranges was divided into consecutive thirds as closely as possible. The third encompassing the highest, middle, and lowest scores, were designated as the high, middle and low sub-ranges. Transformation instructions were then included in the computer input, such that each subject's and therapist's score (the therapist ranges having been derived separately) for each of the ten questionnaire variables, was treated as one of three possibilities, namely high, medium or low. These three categories described the degree with which a subject was felt as manifesting the specific variable relative to the other subjects and not in an absolute sense. In the case of the AB-Scale, we defined the traditional A, AB, and B categories by our low, medium, and high sub-ranges, respectively. The scores limiting each of our sub-ranges were slightly different from those used to delimit A, AB, and B in past studies with this test; however, the basic principle behind deriving the limits were the same in the present and the past studies. The differential size and nature of our own population from those of previous studies was obviously the responsible factor.

STATISTICAL MANIPULATIONS

(RETROSPECTIVE REVIEW)

As part of the preliminary approach to the planning of our study, data from the previously described 12-month review (see Table 1) was examined. Tables were derived, by the author, to examine the effect of a number of independent (mostly demographic) variables on dropout from the E.T.U. 30-day outpatient program. Cell percentages and chi-square were calculated for each table to identify the relationships between variables and the predictive significance of a given relationship.

(PHASE I)

In effecting the first segment of our general plan, computer comparisons exploring the effect of our population's demographic, patient specific and therapist demographic statistics on attendance status (i.e. dropout vs. remainer) were carried out. Cell percentages and a chi-square test of significance for each table were obtained.

(PHASE II)

To carry out the second portion of our plan,
between patient and therapist questionnaire scores, and attendance status was examined using computer derived two-way tables and manipulations identical with those described for phase I.

(PHASE IIIA)

In order to test the first system of differential patient therapist matching, three-way tables comparing the ten patient questionnaire variables, by the ten therapist questionnaire variables, by attendance status, were derived. Statistical operations carried out for the first two phases were repeated with these results as well.

(PHASE IIIB)

The second system of differential matching was explored by eliciting three-way computer tables comparing patient's A-B score and therapist's A-B score, by diagnosis, by attendance status. Statistical manipulations were again the same.

RESULTS

Dropout Rate

Of the 88 patients in our study 22, or 25%, met the criteria for dropout.

Hypothesis I

Except with regard to patient's race, our first hypothesis was upheld by our findings. Neither the age, sex, marital status nor religion of the patient seemed to be predictive of his persistence in outpatient therapy. Although, at first glance, a positive relationship seemed to exist between a patient's being over 40 years of age and his remaining in therapy, (only 1 of 12 over-40 patients dropped out), further examination revealed that a disproportionately high number of these over-40 individuals carried the diagnosis of psychosis. The latter, as we shall indicate shortly, was demonstrated as being highly predictive of one's remaining in therapy and undoubtedly was responsible for the low attrition rate seen in this older group. Although not significant, a trend concerning patient marital status was noted. Being separated divorced or widowed made a patient slightly more susceptable to dropout ($p < 0.10$). Single and married patients, on the other hand, were equally at risk for becoming dropouts or remainers.

Unexpectedly, race proved to bear an important relationship to premature termination. Of the 15 black subjects in our

TABLE 2

HYP.I	Dropout	x	Age				NS	
		x	Sex				NS	
		x	Marital Status				NS	p 0.10
		x	Religion				NS	
		x	Race				*S	p 0.025
HYP.II	Dropout	x	Socioeconomic Class				NS	p 0.10
HYP.III	Dropout	x	Education				NS	
HYP.IV	Dropout	x	Diagnosis				*S	p 0.01
HYP.V	Dropout	x	Suicide				NS	
MISC.	Dropout	x	OccupHH/Ref.Source/#days hosp				NS	
		x	Previous Hospitalization				NS	p 0.10
		x	Therapist age/sex/race/marital status/educ/occup				NS	
HYP.VIa.	Dropout	x	Pt.Anxiety				*S	p 0.025
VIb.		x	Pt.Dependancy				NS	
VIc.		x	Pt.Dominance				NS	
VId.		x	Pt.Authoritarianism				NS	
VIe.		x	Pt.Hostility				NS	
VIf.		x	Pt.Impulse Control				*S	p 0.05
HYP.VII	Dropout	x	Pt."N"	x	Rxist "N"		NS	
		x	Pt."M"	x	Rxist "M"		NS	
		x	Pt."C"	x	Rxist "C"		NS	
HYP.VIIIa.	D-out	x	Pt.Low Anx	x	Rxist "N"		NS	
				x	Rxist "C"		NS	
				x	Rxist Dep		NS	
				x	Rxist Dom		NS	
VIIIb.	D-out	x	Pt.High Dep	x	Rxist "N"		NS	
				x	Rxist "C"		NS	
		x	Pt.High Dom	x	Rxist "N"		NS	
				x	Rxist "C"		NS	
				x	Rxist Dom		NS	
VIIId.	D-out	x	Pt.Auth	x	Rxist Auth		NS	
VIIIe.	D-out	x	Pt.Host	x	Rxist Host		*S	p 0.05
VIIIf.	D-out	x	Pt.Low ImpC	x	Rxist ImpC		NS	
		x	Pt.High ImpC	x	Rxist ImpC		*S	p 0.02
HYP.IX	Dropout	x	Pt.Dx	x	Rxist A-B		NS	
				x	Rxist "A"		*S	p 0.05
				x	Rxist "B"/"AB"		NS	
		x	Pt.AB	x	Rxist AB		NS	
MISC.	Dropout	x	Pt.Low"M"	x	Rxist Host		*S	p 0.01
		x	Pt.Med"M"	x	Rxist Host		NS	
		x	Pt.High"M"	x	Rxist Host		NS	
		x	Pt.HighImpC	x	Rxist "C"		*S	p 0.05
		x	Pt.Low ImpC	x	Rxist "C"		NS	p o.01

study, 53% (versus an expected* 25%) dropped out of therapy. This relationship was significant at the $p < 0.025$ level. White patients, though tending toward being remainers, (81% remained versus an expected 75%) had an equal chance, statistically, of dropping out or remaining.

Hypothesis II

The variable of socioeconomic class as measured by the Hollingshead-Redlick criteria, did not significantly predict the dropout phenomenon. Only one trend was observed, the significance and validity of which is somewhat questionable. When class III patients were compared to non-class III patients (i.e. classes I, II, IV, V, the former manifested a tendancy toward remaining in therapy ($p < 0.10$) while the other group was equally prone to dropout and to remaining.

Hypothesis III

Surprisingly, no relationship between the highest level of education completed by the patient and dropout, could be discerned. Although our subjects comprised a rather broad level of educational attainment, no trend with respect to dropout was demonstrated.

*By an expected percentage, we mean the value which would be dictated, assuming the variable in question (race in this case) was completely independent of persistence in therapy.

Hypothesis IV

As we predicted, diagnosis exhibited a significant relationship with regard to persistence in outpatient therapy. Comparison of seven diagnostic categories (situational/adjustment reaction, character disorder, neurosis/neurotic depression, latent/incipient schizophrenia, pschosis, organic brain syndrome and alcohol/drug addiction) with dropout, was carried out. Because the fourth, sixth and seventh diagnostic categories contained 6, 1 and 2 patients, respectively, and their contribution to chi-square would, therefore, be high and somewhat misleading, several of the categories were "lumped" tpgether.

In comparing patients with a diagnosis of either psychosis or latent/indipient schizophrenia to a second group of patients with any other diagnosis, we noted a relationship significant at the $p < 0.01$ level. It was apparent that a patient's being diagnosed as overt or incipient schizophrenic was highly predictive of his remaining in the E.T.U. outpatient program. On the other hand, the second stipulation of our hypothesis, namely that neurotics would tend to dropout, could not be statistically upheld. Although, slightly more than the expected number in this diagnostic group dropped out, no singificant relationship or suggestive trend could be identified.

Hypothesis V

Fifty-eight precent (58%) of the subjects in our study had exhibited some suicidal ideation or behavior. Of this

58%, 10% (or 6% of our total population) had made actual suicide attempts, 63% (or 36% of our total population) had made gestures, and 27% (or 16% of our total population) had only expressed suicidal thoughts. Nonetheless, as we expected, none of these variables bore any relationship to persistence in followup therapy.

Miscellaneous Patient and Therapist Variables

Data on a number of other patient and therapist variables was gathered and examined, for a relationship to premature termination. Because of an inadequate foundation upon which to base predictions concerning these variables, hypotheses were not formulated. In any case, neither the occupation nor education of the head of the patient's household, the referring agent, the number of inpatient hospital days on E.T.U. nor the number of outpatient appointments made, had any effect upon a patient's persistence in therapy.

Only six of our 88 subjects had been hospitalized on E.T.U. prior to the hospitalization under study; therefore, little could be said concerning the effect of familarity with the unit on dropout. On the other hand, of those 16 patients in our population who had prior hospitalization at some other institution, 94% versus an expected 75% remained in therapy. Although not significant ($p < 0.10$), this difference was suggestive of a possible trend for patients with previous psychiatric inpatient experience to be less dropout prone than an individual for whom E.T.U. comprised the initial hospitalization.

In a similar vein, it would be inappropriate to discuss the relationship of outpatient family therapy, couples therapy and home visits to persistence in the outpatient program. Too few patients had either of the latter three treatment modalities as part of their therapy experience to justify our exploring this issue. It was, however, of some interest to observe that all four patients who participated in family therapy and eleven of the thirteen patients who participated in couples therapy, remained in followup while only five of the nine patients involved in home visits remained.

Although, in our review of the literature, mention was made of the few studies which chose to explore therapist characteristics as they related to dropout, few predictions could be made, with confidence, regarding such variables. Therefore, data concerning the demography of team leaders was examined without specific hypotheses in mind. Of those characteristics under scrutiny, namely therapist age, sex, race, marital status, degree of experience on E.T.U., education and occupation (i.e. title), none were significantly related to patient dropout. The only trend observed was that therapists over the age of 39 tended to have slightly higher dropout rates ($p < 0.10$).

Of the six personality variables measured for therapists by the true-false questionnaire, none showed a significant relationship to patient's persistence in therapy. Only that of therapist hostility exhibited a minor trend with low hostility therapists tending to have fewer dropouts ($p < 0.10$). Middle and high hostility therapists were not, however, prone to having their patients dropout or remain.

Hypothesis VI

a) As anticipated, patient's anxiety did bear a significant relationship to premature termination. When compared to the combined group of patients rating in the middle and high subranges, patients rating low on anxiety had a significantly greater predilection for dropping out ($p < 0.025$). That is to say 44% versus an expected 25% of low anxiety patients terminated prematurely. Although a trend for high-anxiety individuals to remain in therapy was apparent, this relationship was not significant ($p < 0.10$).

b) & c) Neither a patient's dependency nor dominance ratings were predictive of persistence in therapy.

d) No significant relationship between patients' authoritarianism and dropout was discernible. When compared to the combined group of patients rating in the middle and high subranges, patients rating low on authoritarianism had a slight tendancy toward remaining in therapy ($p < 0.10$).

e) A patient's hostility rating was not predictive of persistence in therapy.

f) Although significant, the relationship evident between patients' impulse control and their tendancy to dropout, was somewhat puzzling. An individual's scoring in the middle subrange for impulse control was predictive of his remaining in therapy ($p < 0.05$). On the other hand, individuals scoring high or low on this variable had an equal chance of dropping out or remaining.

Relationships Between the Key Individual Variables

Once four variables, namely patient's race, diagnosis, anxiety and impulse control, had been identified as bearing a significant relationship to dropout, comparisons between these variables themselves were carried out. The aim in doing this was to identify a situation, if any, in which one of the four variables might have exerted its effect on dropout secondarily, by nature of its primary effect on one of the other variables themselves.

Two-way frequency tables were derived by computer, comparing each of the four variables with each of the other three variables. As determined by the nature of the clustering of patients in the various cells of each comparison, the variables of diagnosis and patient race exerted their effect on dropout independently of each other. In addition, patient race and patient impulse control as well as patient diagnosis and patient anxiety, were noted as not interacting in their effect on dropout.

In comparing patient diagnosis and impulse control, we noted that neurotic patients were significantly more often in the medium subrange for impulse control than not ($p < 0.05$). Since we have already indicated that medium impulse control patients showed a significant tendancy for remaining in therapy, while a patient's being diagnosed neurotic had no significant effect on persistence in therapy, one might speculate that controlling for impulse control would bring out our predicted higher dropout rate for neurotic patients.

However, this did not prove to be the case and medium impulse control neurotic patients did not show a predisposition for either dropping out or remaining. Thus, there was little evidence that these two variables were affecting dropout in any interrelated manner.

In comparing race and anxiety, it was noted that black patients had a tendancy, although not significant, to be more frequently low on anxiety than expected ($p < 0.10$). White patients, on the other hand, distributed equally among all three subranges of anxiety.

Hypothesis VII

Neither the congruence nor polarity of a patient and his therapist's expectations of the therapist's role in an anticipated interaction, were significantly predictive of persistence in that interaction. That is to say, for example, the fact that both patient and his therapist had the same (i.e. congruent) expectation that the therapist's role would be a highly nurturant one, had no effect on the patients remaining in followup therapy. Similarly, the fact that a patient expected his therapist's role to be highly critical, while the therapist held the polarized expectation that his role would be relatively uncritical (i.e. low critical), had no effect on the patient's persistence in therapy.

Hypothesis VIIIa

Low anxiety patients, whom we have already shown to be more prone to premature termination, did not dropout significantly less when paired with critical-expecting or dominant therapists. In addition, this group could not be demonstrated as showing a greater tendancy to dropout with nurturant-expecting or dependent therapists.

The only trend which was evident, was that low anxiety patients exhibited a greater tendancy for premature termination when paired with a team leader in the medium dominance subrange than when paired with one who scored in the high or low subranges ($p < 0.10$). Medium and high anxiety patients tended ($p < 0.10$) to remain regardless of their therapist's dominance rating.

Hypothesis VIIIb

Being paired with a nurturant-expecting or critical-expecting therapist, had no effect on a high dependency patient's persistence in therapy. In addition, no other differential pairing of patients with a given level of dependency and therapists of a given role expectation, bore a significant relationship to dropout.

Hypothesis VIIIc

Patients who rated high on dominance did not exhibit less dropout when paired to therapists who were highly nurturant-expecting or low in dominance. Nor did such patients dropout more than expected when paired to high critical-expecting or high dominant therapists.

Hypothesis VIIId

Neither the congruence nor disparity of authoritarianism ratings of a patient and his therapist, had any significant effect on the patient's remaining in therapy.

Hypothesis VIIIe

Although low hostility patients exhibited a trend toward dropping out less when paired with low hostility therapists (versus both medium and high hostility therapists), this tendancy was not significant ($p < 0.10$). However, when compared to the combined group of low hostility patients

whose therapists were either medium or high on hostility, the group with low hostility therapists had significantly less dropout ($p < 0.05$).

Interestingly, when high hostility therapists were viewed as a separate group, they were noted to keep in therapy significantly more medium hostility patients than expected. On the other hand, this group had a greater dropout rate among the low hostility patients they saw than was expected. High hostility patients paired to therapists in this group had an equal chance of dropping out or remaining.

Hypothesis VIIIf

Contrary to our prediction, low impulse control patients did not dropout less when paired with high impulse control therapists than when paired with therapists rated medium or low for this variable. The impulse control rating of his therapist had no effect on the persistence in therapy of either the low or medium impulse control patient. However, high impulse control patients had a significantly ($p < 0.02$) higher dropout rate when paired with low impulse control therapists and lower dropout rate when paired with therapists rated high for this variable.

Hypothesis IXa

As indicated in the findings above psychotic patients dropped out of therapy significantly less than non-psychotic patients. The A-B rating of a given psychotic patient's therapist had no effect on his persistence in therapy. However, when looked at from the standpoint of therapist type, "A" therapists were noted as having a significantly lower rate of dropout with their psychotic patients and significantly higher rate of dropout with their neurotic patients ($p < 0.05$) than with their non-psychotic and non-neurotic patients respectively.

Hypothesis IXb

The A-B rating of the therapists of neurotic patients had no significant effect on those patient's persistence in therapy. Strangely the only trend ($p < 0.10$) noted was that neurotics had a tendancy of dropping out less with "AB" therapists than with "non-AB" therapists (i.e. non-AB implying the combined group of "A" and "B" therapists). When looked at from the vantage point of therapist characteristic, neither "AB" nor "B" therapists had any differential effect on the persistence in therapy of patients of one diagnostic group over patients of another. (The three diagnostic groups compared here were neurotics, psychotics and a third group made up of patients with diagnoses of character disorder, situational reaction and adjustment reaction. The two patients with diagnoses of addiction and one with a diagnosis of organic brain syndrome were excluded from this comparison.)

Hypothesis IXc

Neither the polarity nor congruence of A-B ratings of a patient and his therapist, had any significant effect on the patient's persistence in therapy.

Relationship of Miscellaneous Interaction Patterns to Dropout

Of those patient-therapist characteristic pairings examined, for which hypotheses had not been proposed, interesting findings were revealed.

Although not significant, a trend for low impulse control patients to remain when paired with medium model-expecting therapists and to dropout when paired with high model-expecting therapists, was evident ($p < 0.10$). Though the small number of subjects per cell in the tables of these comparisons limited our interpretation of the data, it was at least of anecdotal interest that all six low impulse control patients paired to medium model team leaders remained while 56% (versus an expected 30%) of those paired to high model team leaders dropped out.

Secondly, it was noted that the group of low model-expecting patients paired with either low or medium hostility therapists, when compared to the group paired with high hostility therapists, demonstrated significantly less dropout and more remaining ($p < 0.05$). Middle and high model-expecting patients, regardless of the level of hostility of their team leader, had an equal chance of dropping out or remaining.

Thirdly, we observed that high impulse control patients when paired to low critical-expecting therapists, remain in therapy significantly more than when paired to non-low (i.e. medium and high combined) critical-expecting therapists ($p < 0.05$). Low impulse control patients, on the other hand, tended to remain in therapy more with high critical-expecting therapists, however, this relationship was not significant ($p<0.10$).

DISCUSSION

Dropout Rate

The fact that our dropout rate, namely 25%, was still considerably lower than that noted in previous studies, points up the importance of reitterating the ways in which our venture differed from those studies. Although our criteria for designating someone a dropout were derived arbitrarily, there is little reason to believe they were any less stringent than those of other authors. Upon examining the parameters used in the past as outlined in our literature review, one might even venture to say that our own criteria were the more rigorous. Whereas most investigators divided their populations into dropouts and remainers on the basis of the mean number of appointments kept by all subjects, we accounted for both cancelled and broken appointments, and considered the therapist's compliance with the act of termination. (i.e. considered whether termination was with the advice and consent of the team leader.) If one accepts the consideration that dropout criteria, though clearly not analagous, were not the key factor responsible for the differences in dropout rate, one must look to other differential factors.

Among such differential factors, that of the nature of the population would be of obvious importance. The relationship of various subject characteristics to persistence in therapy shall be discussed below. Of these, patient race and diagnosis appeared to have the most predictive significance. The fact that none of the studies discussed in our literature review involved a greater percentage of black patients (whom we noted as more dropout prone) than

did our own, suggests that race may not be one of the factors responsible for our lower dropout rate. On the other hand, the fact that 32% of our subjects carried a diagnosis of psychosis (including incipient schizophrenia), which our findings indicate is a diagnosis significantly related to dropout, may suggest that that variable was influential in keeping our dropout rate so low. Most of the dropout rates which we had quoted above were from studies involving predominantly or exclusively neurotic patients. Interestingly, the only study quoted in our discussion of dropout rate which involved a considerable proportion of psychotic patients (37%) had a low dropout rate of 6%.[41] However, psychotics made up 55% of the dropouts in that study and, as we noted previously, the population as a whole was, to begin with, highly selected.

The second differential factor which may have in some way effected a lower incidence of premature termination among our subjects, was the nature of our setting. As we have described in more detail previously, the active, intensive, crisis-oriented approach of E.T.U. often establishes a firm attachment between patient and unit or between patient and team leader. This feeling often carries over to the out-patient follow-up and might deter an individual from dropping out. The possible advantages of a low patient to therapist ratio and early involvement of friends and significant others during the inpatient phase, as we mentioned, might also assist in creating a setting conducive to a patient's remaining in therapy.

As we have described in our methodology section, the selection of a team leader for a given patient was made in a uniform, but by no means random, fashion. One of the criteria for patient and therapist pairing, was the latter's interest in working with the patient. As far as could be determined, former dropout studies used more random procedures in their pairing and might have had a higher incidence of dropout as a result.

A last differential factor to be considered in exploring the relatively low dropout rate exhibited by our subjects, is the nature of the outpatient therapy itself. Patients entering the E.T.U. outpatient program are aware of the brief commitment which the program entails. It may be awareness of the latter which persuaded an individual who was contemplating dropout to "hold out" a little longer. In previous investigations the treatment period was uniformly greater than that of E.T.U. and would have made "holding out" less likely. It should be stressed once again that the discrepancy in time commitment between previous studies and our own, makes the preceding comparison of dropout rates somewhat tenuous.

Before leaving the subject of dropout rate, brief mention should be made of the 8% difference between the rates noted in this study and that in the twelve-month retrospective review. The issue of false negatives alluded to in the methodology section, could not have been responsible for the entire difference. In all probability, our more rigorous criteria for dropout were a key factor. In fact, one is surprised that the difference is only 8%. It is

possible that knowledge of the study's aims, inspired therapists to make more extensive efforts in order to keep their patients from dropping out, and that this kept the difference down to 8%. One might also consider that the therapists involved in our study, most of whom had been working at E.T.U. during the time period covered by our twelve-month review, were more experienced and were, therefore, able to keep the increase in dropout rate to only 8%. However, as our findings regarding miscellaneous individual variables revealed, a therapist's experience was unrelated to his patient's persistence in therapy.

Individual Patient and Therapist Characteristics

Despite the relatively unique features of our study, our finding that neither a patient's age, sex, marital status nor religion bore a relationship to his persistence in therapy, was in agreement with previous investigations of dropout. In contrast, our observation that black patients were significantly more prone to dropout was not specifically hypothesized. Most dropout research, as well as our own twelve-month review, failed to demonstrate a relationship between race and attrition. In order to explain our finding, one might propose that the fact that E.T.U. is not specifically oriented toward dealing with black patients is, in part, responsible. Although five of the permanent staff members are black, none of them hold the few supervisory positions which do exist. Even though policy decisions made on E.T.U. emanate, to a large degree, from the input of the entire staff, the black members have not been as active in their encouragement of innovative approaches

with black patients as they might be. One significant modification which has been made in the outpatient program with black lower socioeconomic class patients in mind, has been the instituting of home visits. Patients for whom it is too inconvenient or incongruous with their life style and economic situation to come to C.M.H.C. for outpatient therapy are now able to elect to be visited at home by their therapist. As we noted in our results section, too few of our subjects participated in the home visit program to allow us to discuss its effect on dropout. Nonetheless, in light of our findings with regard to race, it would be most interesting to further explore the relationship of the program to premature termination by black patients.

Despite the insufficient race-specific orientation we have just mentioned, other factors must have undoubtedly contributed to the greater attrition seen with our black subjects. As well as could be gleaned from past dropout research, few other institutions, if any, were more flexible and specialized in their treatment of black patients than E.T.U. Therefore, some other factors would also appear to be involved. In further exploring the variable of race it became evident that a considerable number of our black subjects were noted to score low on anxiety. The latter (i.e. low anxiety) was noted as being significantly predictive of dropout for our whole population as well as for only the white individuals in the population. Although there was a trend ($p < 0.10$) for black patients to score low on anxiety, they were unfortunately too few in number to allow us to make a meaningful statement regarding the incidence of

dropout among subjects who were both black and low in anxiety. It would, however, be enlightening to make future attempts at discerning whether the disproportionate amount of premature termination among blacks is related to their denying symptoms of anxiety. Why blacks should admit to less anxiety, whether this finding continues to prevail and whether one is justified in using the same measure for anxiety in two different racial groups, are questions which deserve further analysis.

Of interest in our observations was the fact that while race was significantly related to dropout, neither socioeconomic class nor education were predictive of dropout. These findings were in contrast to those of previous investigations which found that lower socioeconomic position and lower level of education attained, were both predictive of dropout. With regard to social class, our results may have been a manifestation of the effect that the broad based social class backround of the therapists themselves had on keeping class IV and class V patients in therapy. On the other hand, the predetermined brief nature of the outpatient contact may be more appropriate for and deter dropout among these individuals. Since patterns of education tend to follow, in many cases, those of social class, it may be that our inability to demonstrate an inverse relationship between level of education attained and premature termination follow from our results regarding socioeconomic status. One might also speculate that the brevity of E.T.U.'s outpatient program makes it less analagous to the pattern represented in the school situation. Therefore the "persistence in a two-way interaction over time," which we postulated initially as a

basis for the relationship between education and dropout, might be less appropriate on E.T.U.

The only other major demographic variable for which we noted a significant relationship to dropout, was that of diagnosis. Despite the fact that the prediction we made on the basis of our twelve-month review, namely that psychotics would be prone to remaining in therapy, was upheld, this was not observed in most of the former dropout studies. As was indicated earlier in our discussion, little of the past research involved significant numbers of psychotic patients, if any at all. Therefore, it would be difficult to make a meaningful comparison with respect to this variable. Nonetheless, although we were unable to show neurotic patients as having higher dropout rates, it still becomes necessary to explain why psychotics have a proclivity for remaining in therapy. An approach to such an explanation was not undertaken in the present venture. Many therapists agree that there is something about the nature of a psychotic patient which makes for his forming a stronger, though often dependent, bond to his therapist. Although one might speculate that the relationship established between patient and therapist in which the psychotropic drugs are a key unifying element, (i.e. the relationship often noted between the psychotic patient and his therapist) would be less likely to end in dropout, convincing evidence to support this speculation is presently unavailable. The relationship of medication usage to dropout, was not explored in this undertaking; however, we would strongly encourage its pursuit in the future.

The fact that we were unable to show a tendancy for dropout among subjects with a diagnosis of neurosis is also not well understood. Since we had been able to demonstrate this (in our twelve-month review) as had other researchers, one must consider what factors might have been unique about the neurotic patients in our study. Of possible significance was the fact that over 95% of our neurotic patients had depression as a major element of their illness. Few other characteristics were as distinguishing of this group of individuals as was the depressive element of their problem. If the latter, in some yet unexplored manner, deterred a patient from terminating prematurely, we would be able to explain why we did not observe a higher dropout rate. The data from the present study was too limited in scope to allow further evaluation of this problem.

The fact that we once again found suicidal ideation and behavior to be unrelated to premature termination, makes the "harbinger" theory we proposed in o justification section, even less tenable. Nonetheless, it is necessary to keep in mind that the suicidal potential we measured was on the basis of the patient's history at the time of his coming to E.T.U. Ideally it would have been useful and important to follow and reassess our subjects for suicidal behavior after their leaving E.T.U. Unfortunately, this was technically not possible.

Of special interest was our observation that none of the therapist demographic and personaltiy characteristics studied in this undertaking demonstrated a significant relationship to dropout. Although there was a slight trend

for therapists over the age of thirty-nine to have their patients dropout, there were too few therapists in this group to permit anything more than mention of this trend. The one other therapist variable for which a trend was noted, was that of hostility. The tendancy for low hostility therapists to have less dropout, might be indicative of this group's differential ability to create an environment or therapeutic relationship in which the dropout prone individual would be more likely to remain. In any event, the lack of predictive value of individual therapist traits adds creedence to our suggestion that more meaningful results regarding premature termination may come from investigation of the therapeutic interaction rather than of the isolated variables which go into making up that interaction.

Although we noted significant relationships between several of the patient personality characteristics and dropout, we shall reserve discussion of these findings to our discussion of the interaction between patient and therapist personality characteristics.

Patient-Therapist Interaction Characteristics

Of the possible permutations of patient-therapist pairing, one based on congruent therapist role expectations might seem as though it would be effective in minimizing dropout. As our literature review illustrated, however, such has not always

been the case. Our measure for assessing patient and therapist expectancies of the therapist role revealed that neither mutuality nor polarity of expectation (between the two parties involved in therapy) was useful for predicting persistence or dropout. Why expectations were not correlated is something not readily explained by the data available. Interestingly, however, we did observe that in certain instances the role expectancies of therapists, when taken together with personality traits of patients (rather than with role expectancies of patients), were useful in predicting dropout. These findings, which were described in the miscellaneous interaction pattern subsection of our results, shall be discussed below.

In our review of past research, we noted that low anxiety was one of the non-demographic characteristics most reliably predictive of dropout from outpatient therapy. In our study, the same finding was evident; low anxiety patients were significantly prone to dropout while high anxiety patients were significantly prone to remaining. Of the several explanations described in more detail in our literature review, that which proposed anxiety as being a "manifestation of the tension prerequisite to keeping someone in therapy," seemed most reasonable. In an attempt to further explore the issue of anxiety from the standpoint of a patient-therapist interaction, rather than as an isolated variable, the effect of therapists with given characteristics being paired with low anxiety patients was determined. If our proposed explanation of why low anxiety led to dropout, was true, we might have expected to see an accentuation of this phenomenon when the low anxiety patient was paired to a therapist who was either low in anxiety, high in dependency or expectant of being nurturant in the therapy situation. Such a therapist would be more likely to reinforce the patient's lack of "prerequisite tension"

than challenge it. In the same vein, a therapist high in dominance or one expectant of being critical in the therapy situation would have been more likely to have had a lower dropout rate with low anxiety patients than therapists at the opposite end of the spectrum for these two variables. However, none of the selected patient-therapist pairings we have just described were observed to affect the tendancy for dropout among our low anxiety subjects. This may be an indication that our proposal regarding the mechanism of low anxiety, was incorrect.

In light of the reliability of this variable (as measured by items from the Taylor Manifest Anxiety Scale) in predicting dropout, further research in the area of patient anxiety, with more elaborate examination of the relationship between it and race, would be strongly indicated.

Two other non-demographic patient characteristics which were shown by other authors to be significantly related to persistence in therapy were dependency and dominance. As we described in more detail previously, a patient low in dependency or high in dominance had been noted in the past as being likely to dropout. We suggested that the dependent individual would be expected to remain in the supportive environment of the therapeutic interaction for as long as possible, where as the dominant individual would be likely to feel restricted or uncomfortable, view the situation as "limiting or personally imposing," and thus dropout. We were unable to demonstrate either of the expected relationships dealing with these two personality

characteristics.

Although neither dependency nor dominance, as a discrete variable was predictive of dropout, an attempt was made to study each as part of a patient-therapist pairing. We specifically looked to see if highly dependent subjects dropped out less with therapists who expected their own role in therapy to be a nurturant one, and more with therapists who expected to be critical in the therapy situation. In addition, we looked to see if a high dominance subject paired to a low dominance or "nurturant-expecting" therapist had a greater liklihood of remaining in therapy than did one paired to a high dominance or "critical expecting" therapist. With neither of the two variables, were any of the expected interaction patterns demonstrated.

The reasons for our not observing the expected results with regard to dependency and dominance were not clear. One possibility considered, dealt with the fact that neither of the measures with which we attempted to assess the variables, had been used before in dropout research. In addition neither measure came from a single source or had been tested for internal consistency. It might be valuable for subsequent pursuits to retest the hypotheses discussed here, using the M.M.P.I. or some other measure used in previous premature termination research.

Using a well tested measure, we were unable to delineate a significant relationship between a patient's authoritarianism and dropout. In addition, we could not show that differential

pairing of patient and therapist according to the authoritarianism of each, had any effect on the patient's persistence in therapy. We were unable to provide an explanation for our lack of findings with regard to this variable.

On the basis of previous findings, we hypothesized that hostile patients would be more likely to remain in therapy than those judged to be low in hostility. As was evident from our review of the literature, not many investigations studied this variable and not all which did study it, came up with the same conclusions. Thus, our hypothesis with regard to this personality characteristic were not based on as sound a foundation as might have been desirable. The fact that patient hostility, as an isolated variable, showed no relationship to persistence in therapy, therefore, was not totally unexpected. As noted above, however, it was interesting to observe that a therapist's being low in hostility made it slightly more likely, though not significantly so, that his patient would remain in therapy.

Of even greater interest than the latter finding, were the results concerning hostility as a factor in the patient-therapist interaction. While patient hostility itself was unrelated to persistence in therapy, we did note that low hostility patients dropped out significantly less when paired with low hostility therapists than when paired with "non-low" (i.e. medium or high) hostility therapists. This is suggestive of the possibility that one of the reasons a low hostility patient decides to leave the therapy situation prematurely, is that he finds the therapist's hostile behavior too

uncomfortable or at odds with his own, to permit him to remain.

Also noted in relationship to the foregoing variable, was the fact that, when examined as a group, high hostility therapists had significantly greater attrition rates with low and high hostility patients, while they kept in therapy significantly more medium hostility patients. Although the exact meaning of the latter finding was unclear, it appeared that hostility might be one variable for which selective matching of patients and therapists, in order to reduce dropout, would be definitely worth exploring.

The last non-demographic personality variable studied was that of impulse control. Unexpectedly, medium impulse control patients exhibited a significant propensity for remaining in therapy, while patients who resided at either end of the spectrum of this variable, had an equal chance of dropping out and remaining. Whether residing in the medium subrange was a secondary manifestation of some underlying stable quality which also enhanced a patient's remaining in therapy, cannot be determined without further study.

In relation to the way in which impulse control played a role in the patient-therapist interaction, several interesting findings were described with our results. While both low and high impulse control patients were noted in the preceding paragraph as not having a predilection for either dropping out or remaining, only the low impulse control patients sustained this balance regardless of their therapist's impulse control. High impulse control patients, on the other hand, demonstrated a significantly greater degree of premature termination when paired with low impulse control therapists and a significantly lesser degree when paired with high impulse control therapists. Therefore, it would appear that in matching patients and

therapists in an effort to minimize dropout, a key variable to observe would be that of impulse control. In so doing, special care would have to be taken to avoid placing a patient with a high level of impulse control with any therapist other than one with the same level. It is likely that the high impulse control patient may be shown more clearly, in the future, to be one who cannot tolerate, and is more likely to dropout with, therapists who have other behaviors and traits incongruous with his own. Before ending our discussion of this variable, however, brief mention should be made of one of the miscellaneous patient-therapist interaction patterns described with the rest of our results. We found that high impulse control patients paired with therapists who expected their own behavior in therapy to be relatively non-critical, dropped out significantly less than those paired with therapists who were in the medium or high subranges for critical role expectancy. This would reemphasize the potential value in using this personality characteristic as one possible focus in selectively pairing patient and therapist.

The final relationship explored, involved the "A-B variable." Although the latter had been shown to be useful in the prediction of the degree of improvement particular therapists had with patients of different diagnoses, little had been done to see whether it would also be useful in predicting the degree of dropout these therapists had with patients of various diagnoses. From the studies which used therapist improvement rates as a criterion for the "success" of a patient-therapist match, we extrapolated to develop our own

hypotheses. Specifically, we proposed that psychotic patients would dropout significantly less with "A" therapists than "B" therapists. Neurotic patients on the other hand were expected to exhibit less dropout with "B" as opposed to "A" therapists. As our findings indicated, however, neither hypothesis was upheld. That is to say, the "A-B" type of a patient's therapist had no effect on that patient's persistence in therapy, regardless of his diagnosis. What was demonstrated, however, was that when viewed as a group, "A" therapists had significantly less dropout among their psychotic patients than among their neurotic ones. Neither "AB" nor "B" therapists demonstrated such a differential ability to keep patients of a certain diagnosis in therapy. It is interesting to recall that the findings in past research with regard to "A" therapists were more easily repeatable than those with regard to "B" therapists. In any event, it would appear from our results that the "A-B variable" may have some role in selectively matching patient with therapist, in an effort to prevent a given therapeutic interaction from ending prematurely because of dropout. Further investigation, with larger samples, would be an important next step in evaluating the possibilities for such selective matching .

SUMMARY

Using written questionnaires, we measured a number of personality characteristics of all those patients admitted, during a four-month period, to a psychiatric crisis intervention unit. Measures of therapist role expectancy and vocational interest were also administered and demographic data was collected. Identical measures and demography were collected from the therapists assigned to these patients. Those individuals who were discharged to the outpatient followup program of the unit, were carefully observed to determine whether or not they would terminate prematurely. Dropouts and remainers were then compared on the various characteristics assessed. The effect of differential pairings of patient and therapist characteristics on dropout, was specifically examined.

From the results of these comparisons, a number of variables were observed to be independent of dropout. Being black, psychotic or low in anxiety, on the other hand, were significantly predictive of a patient's premature termination, while being medium for impulse control was predictive of his remaining. In addition, differential matches of patient and therapist, on two personality characteristics, namely hostility and impulse control, were noted to bear a significant relationship to dropout. While the mutuality of therapist role expectancy between patient and team leader was unrelated to dropout, the Whitehorn-Betz "A-B" vocational interest scale gave indications of being useful in the assignment of patients with certain diagnoses to specific therapists.

The primary significance of these findings lies in their providing an inroad to the identification of dropout prone individuals. It will be through the latter process that

psychiatric facilities will then be better equipped to develop a more appropriate, modified approach to such patients. The selective matching of patient and therapist on personality traits, has been demonstrated as being worthwhile and potentially useful in the prevention of dropout.

It would, however, be necessary for future research, using larger samples and more thoroughly tested measures, to further elucidate the effect on dropout, of differentially pairing patient and therapist. A prospective investigation, by selectively assigning patients of known characteristics to therapists of known characteristics and observing the incidence of dropout, might provide useful added information. We would also suggest the assessment of improvement parameters prior to and following a patient's termination (be it planned or premature) so their relationship to dropout might be better understood.

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APPENDIX

In order to improve the quality of the treatment to patients on this unit, I would appreciate your completing the following three questionnaires. Your answers will be considered confidential and will not affect your treatment here. For each questionnaire a separate set of instructions are provided. Please be candid in your responses.

Thank you,

David M. Dressler, M.D.
Chief, Emergency Treatment Unit

OCCUPATIONAL INTERESTS

NAME_____ CODE NO._____

For the following items, please respond in terms of the degree of interest you would have in each of the relevant activities, school subjects or occupations by encircling the appropriate answer. Work rapidly.

1.	Marine engineer	Like	Indifferent	Dislike
2.	Photoengraver	Like	Indifferent	Dislike
3.	Making a radio set	Like	Indifferent	Dislike
4.	Looking at shop windows	Like	Indifferent	Dislike
5.	Toolmaker	Like	Indifferent	Dislike
6.	Mechanical Engineer	Like	Indifferent	Dislike
7.	Adjusting a carburetor	Like	Indifferent	Dislike
8.	Manual training	Like	Indifferent	Dislike
9.	Ship officer	Like	Indifferent	Dislike
10.	Cabinet making	Like	Indifferent	Dislike
11.	Building contractor	Like	Indifferent	Dislike
12.	Mechanical drawing	Like	Indifferent	Dislike
13.	Carpenter	Like	Indifferent	Dislike

Answer the following items as truthfully as possible by encircling one of the answers. Work rapidly.

14.	People often disappoint me.	True	False
15.	I think I would like the kind of work a forest ranger does.	True	False
16.	I like mechanics magazines.	True	False
17.	It does not bother me that I am not better looking.	True	False

18.	In school, I was sometimes sent to the principal for cutting up.	True		False
19.	I have mechanical ingenuity (inventiveness).	True	Not Sure	False
20.	I am good at finding my way around strange places.	True	Not Sure	False

THERAPIST EXPECTATIONS (PETI)

Name_____ CODE NO._____

Below you will find pairs of statements describing ways in which other patients expected their therapists to be. Your job is to read the two statements in each pair and then place a check in front of the one you feel is a better description of the way you expect, not what you wish, hope, or would like him to be. There are no right or wrong answers, we are only interested in your opinions. Please be sure to choose one statement from every pair - the one which best fits how you expect your therapist to be.

EXAMPLE. If you feel the statements: "Is likely to give advice" fits your expectations of what your doctor will be like better than the statement: "Is able to sense other peoples' feelings" your answer to the first pair would be as shown below:

1. __✓__(a) Is likely to give advice.
   _____(b) Is able to sense other peoples' feelings.

Begin here:

1. ___(a) Is likely to give advice.
   ___(b) Is able to sense other peoples' feelings.

2. ___(a) Is businesslike.
   ___(b) Cares what other people think of him.

3. ___(a) Is diplomatic.
   ___(b) Is sympathetic.

4. ___(a) Looks for the good points in people.
   ___(b) Is persuasive.

5. ___(a) Is careful not to let people waste his time.
   ___(b) Is concerned with what's right.

6. ___(a) Is calm and easygoing.
   ___(b) Is critical and not easily impressed.

7. ___(a) Is careful not to upset others.
   ___(b) Is likely to keep his irritations or resentments to himself.

8. ___(a) Expects the client to shoulder his own responsibilities.
   ___(b) Tries to discover who's to blame for mistakes made.

THERAPIST EXPECTATIONS CONT.

9. ___(a) Is indulgent and forgiving.
___(b) Judges the behavior of others.

10. ___(a) Is able to sense other peoples' feelings.
___(b) Expects the client to shoulder his own responsibilities.

11. ___(a) Is critical and not easily impressed.
___(b) Is self satisfied.

12. ___(a) Is persuasive.
___(b) Is hard to get to know.

13. ___(a) Cares what other people think of him.
___(b) Is likely to overestimate a person's abilities.

14. ___(a) Is well adjusted and gets along well in the world.
___(b) Has no trouble getting along with people and makes friends easily.

15. ___(a) Is quick to give encouragement and reassurance.
___(b) Likes to do a good job.

16. ___(a) Is well adjusted and gets along well in the world.
___(b) Is able to sense other peoples' feelings.

17. ___(a) Reacts to most people in about the same way.
___(b) Judges the behavior of others.

18. ___(a) Is calm and easygoing.
___(b) Never makes people feel uncomfortable.

19. ___(a) Is conscientious about duties and responsibilities.
___(b) Likes to do a good job.

20. ___(a) Is hard to get to know.
___(b) Looks for the good points in people.

21. ___(a) Is able to change his opinions easily.
___(b) Expects the client to shoulder his own responsibilities.

22. ___(a) Is careful not to let people waste his time.
___(b) Is troubled by the misfortunes of others.

23. ___(a) Is likely to overestimate a person's abilities.
___(b) Is businesslike.

THERAPIST EXPECTATIONS CONT.

24. ___(a) Is likely to give advice.
___(b) Has no trouble getting along with people and makes friends easily.

25. ___(a) Is hard to deceive and does not accept things at face value.
___(b) Is able to sense other peoples' feelings.

26. ___(a) Is not emotional.
___(b) Is sympathetic.

27. ___(a) Is likely to keep his irritations and resentments to himself.
___(b) Is logical and sticks to the facts.

28. ___(a) Is likely to give advice.
___(b) Expects the client to shoulder his own responsibilities.

29. ___(a) Is hard to deceive and does not accept things at face value.
___(b) Is well adjusted and gets along well in the world.

30. ___(a) Reacts to most people in about the same way.
___(b) Is indulgent and forgiving.

31. ___(a) Is self satisfied.
___(b) Is likely to overestimate a person's abilities.

32. ___(a) Is not emotional.
___(b) Is diplomatic.

33. ___(a) Is critical and not easily impressed.
___(b) Never makes people feel uncomfortable.

34. ___(a) Is quick to give encouragement and reassurance.
___(b) Is conscientious about duties and responsibilities.

35. ___(a) Is able to change his opinions easily.
___(b) Tries to discover who's to blame for mistakes made.

36. ___(a) Is well adjusted and gets along well in the world.
___(b) Is likely to give advice.

37. ___(a) Is concerned with what's right.
___(b) Is troubled by the misfortunes of others.

THERAPIST EXPECTATIONS CONT.

38. ___(a) Likes to have a hand in managing other people's affairs.
___(b) Is careful not to let people waste his time.

39. ___(a) Is critical and not easily impressed.
___(b) Is likely to overestimate a person's abilities.

40. ___(a) Is careful not to let people waste his time.
___(b) Is blunt and straightforward.

41. ___(a) Is logical and sticks to the facts.
___(b) Is careful not to upset others.

42. ___(a) Likes to have a hand in managing other people's affairs.
___(b) Is blunt and straightforward.

Please check to see that you have chosen one statement for every pair.

PETI and TETI SCORING KEY

1.	(A)	N+C+
	(B)	N+M+
2.	(A)	N-
	(B)	C-
3.	(A)	M+
	(B)	N+
4.	(A)	C-
	(B)	M-
5.	(A)	N-M-
	(B)	M-
6.	(A)	M+
	(B)	C+N-
7.	(A)	N+
	(B)	M+
8.	(A)	C+N-
	(B)	M-
9.	(A)	C-
	(B)	M-
10.	(A)	M+
	(B)	C+N-
11.	(A)	C+N-
	(B)	M-
12.	(A)	M-
	(B)	N-
13.	(A)	C-
	(B)	M-C-
14.	(A)	N+M+
	(B)	M+
15.	(A)	N+
	(B)	M+
16.	(A)	N+M+
	(B)	N+M+
17.	(A)	N-
	(B)	M-
18.	(A)	M+
	(B)	N+
19.	(A)	C+
	(B)	M+
20.	(A)	N-
	(B)	C-
21.	(A)	C-
	(B)	N-C+
22.	(A)	N-M-
	(B)	C-
23.	(A)	M-C-
	(B)	N-
24.	(A)	N+C+
	(B)	M+
25.	(A)	C+
	(B)	N+M+
26.	(A)	C+
	(B)	M+
27.	(A)	M+
	(B)	C+
28.	(A)	C+N+
	(B)	C+N-
29.	(A)	C+
	(B)	M+N+
30.	(A)	N-
	(B)	C-
31.	(A)	M-
	(B)	C-M-
32.	(A)	C+
	(B)	M+
33.	(A)	C+N-
	(B)	N+
34.	(A)	N+
	(B)	C+
35.	(A)	C-
	(B)	M-
36.	(A)	N+M+
	(B)	N+C+
37.	(A)	M-
	(B)	C-
38.	(A)	M-
	(B)	N-M-
39.	(A)	N-C+
	(B)	C-M-
40.	(A)	N-M-
	(B)	N-
41.	(A)	C+
	(B)	N+
42.	(A)	M-
	(B)	N-

PERSONALITY STYLE

Name_____ Code No._____

THE FOLLOWING STATEMENTS HAVE BEEN USED BY PEOPLE TO DESCRIBE THEMSELVES AND THEIR FEELINGS ABOUT CERTAIN ISSUES.

AFTER READING EACH STATEMENT CAREFULLY, DECIDE WHETHER THE STATEMENT APPLIES TO YOU.

FOLLOWING EACH STATEMENT WILL BE TWO CHOICES: T AND F

IF, FOR YOU, THE STATEMENT IS MORE TRUE THAN FALSE, CIRCLE T.
IF, FOR YOU, THE STATEMENT IS MORE FALSE, THAN TRUE CIRCLE F.

1.	I lose interest in things which I cannot get or do right away.	1.	T	F
2.	I wish I could be as happy as others.	2.	T	F
3.	Even when my anger is aroused, I don't use strong language.	3.	T	F
4.	I like to do things in my own way without regard to what others may think.	4.	T	F
5.	When things go wrong for me, I feel that I am more to blame than anyone else.	5.	T	F
6.	I feel that sex crimes, such as rape and attacks on children, deserve more punishment than mere imprisonment.	6.	T	F
7.	I don't like my friends to console me when I meet with failure.	7.	T	F
8.	I am usually calm and not easily upset.	8.	T	F
9.	I feel like telling other people off when I disagree with them.	9.	T	F
10.	Once a leader has been chosen in a group, he or she should be given undivided respect.	10.	T	F
11.	I prefer to give in and avoid a fight, then to insist on having things my way.	11.	T	F

PERSONALITY STYLE CONT.

12.	Right now I have some money saved up.	12.	T	F
13.	I don't think it is possible to divide people into two distinct classes: the weak and the strong.	13.	T	F
14.	I like to say what I think about things.	14.	T	F
15.	I like to attack points of view that are contrary to mine.	15.	T	F
16.	Life is often a strain to me.	16.	T	F
17.	I like to argue my point of view when it is attacked by others.	17.	T	F
18.	I often end up doing things that I told myself I wouldn't do.	18.	T	F
19.	I sometimes carry a chip on my shoulder.	19.	T	F
20.	I like to be called upon to settle arguments and disputes between others.	20.	T	F
21.	I like to follow instructions and do what is expected of me.	21.	T	F
22.	I never break a date with someone without telling them about it.	22.	T	F
23.	I am not very confident of myself.	23.	T	F
24.	In my opinion there is hardly anything lower than a person who doesn't feel a great love, gratitude and respect for his or her parents.	24.	T	F
25.	Every man for himself is the wisest rule to follow.	25.	T	F
26.	When people are bossy, I take my time, just to show them.	26.	T	F
27.	I think students should allow the teacher to make the final decisions.	27.	T	F

PERSONALITY STYLE CONT.

28.	I like to supervise and to direct the actions of other people whenever I can.	28.	T	F
29.	I don't think people should be expected to shoulder their own responsibilities.	29.	T	F
30.	I am often sick to my stomach.	30.	T	F
31.	I never play practical jokes.	31.	T	F
32.	I have often spent more money than I had, by borrowing on the spur of the moment.	32.	T	F
33.	I feel timid in the presence of other people I regard as my superiors.	33.	T	F
34.	I tend to feel that nowadays, when so many different kinds of people move around and mix together so much, a person has to protect oneself especially carefully against catching an infection or disease from them.	34.	T	F
35.	When planning something, I like to get suggestions from other people whose opinions I respect.	35.	T	F
36.	I find it hard to keep my mind on a task or job.	36.	T	F
37.	When we go out together, I sometimes walk off and leave my friends without telling them about it.	37.	T	F
38.	The way I see it, nowadays more and more people are prying into matters that should remain personal and private.	38.	T	F
39.	When I really lose my temper, I am capable of slapping someone.	39.	T	F
40.	I like my friends to sympathize with me and to cheer me up when I am depressed.	40.	T	F
41.	I feel that I am inferior to others in most respects.	41.	T	F
42.	I frequently find myself worrying about something.	42.	T	F

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